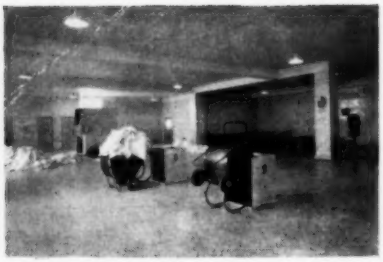
October, 1957

Canadian Hospital

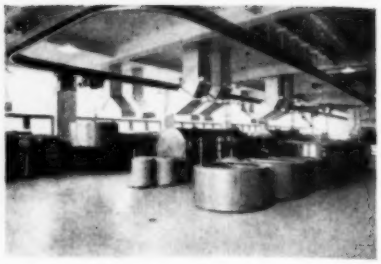
- *"The Children's" of Winnipeg*
- *A Hospital Home Care Plan*
- *Community-Auxiliary Relations*
- *A Social Service in the Hospital*
- *Medical Records in a Small Hospital*

Canadian Hospital Association

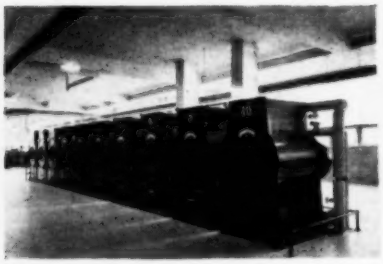


Work is sorted and classified in the soiled-linen room. It is then weighed and placed in easy-to-handle carts which are emptied into chutes leading to laundry.

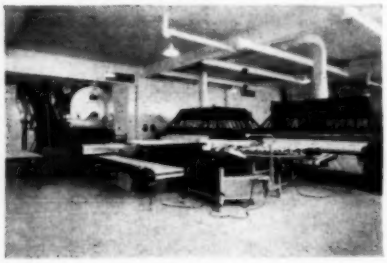
Hoppers feed work from chutes directly into Cascade Unloading Washers. These large-capacity machines with Full-Automatic Controls are the ultimate in labor-saving equipment.



At the touch of a button hundreds of pounds of work are unloaded from washers into extractor containers. Overhead trolley and hoists convey containers to and from 60" Notrux Extractors.

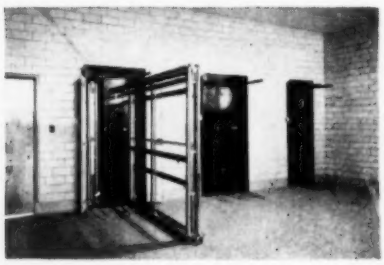


After extraction, work to be dried is conveyed to this battery of Zone-Air Tumblers. A total load capacity of 1100 lbs. indicates the tumblers' value in this high-production operation.

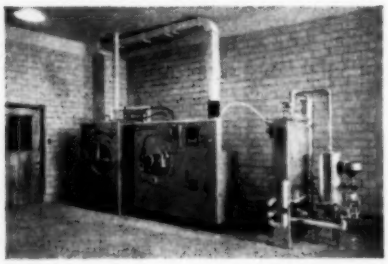


Completely mechanized flatwork finishing reduces operating personnel. Rotaire Conditioning Tumbler, Conveyors, Sager Spreader, Super-Sylon Ironers and Trumatic Folder speed-up work flow.

High-speed finishing of hospital garments and shirts rounds out variety of work laundry handles. Units include Super-Zarmo and Super-Zarmoette Presses and Tiltor Shirt Folder.



Three built-in Blanket and Curtain Dryers indicate the extent of planning and complete range of equipment supplied by the Canadian Laundry Machinery Company in this model installation.



An important part of the all-inclusive service performed by this modern department is the Model 30 Deluxe American-Martin Dry Cleaning Unit. Cleans up to 120 lbs. of work per hour.

Dry cleaning finishing is done with the latest model air-driven AceCo Presses. These presses assure fast, quality finishing with smooth, easy operation and maximum safety.

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Modern premises, ample floor space and the world's finest laundry and dry cleaning equipment – make the laundry of St. Michel-Archange Hospital, Quebec, an ideal example of a fully equipped, efficient service department. The Canadian Laundry Machinery Company's planning help and complete line of equipment played an important role in creating this "dream" laundry. For complete information on how to streamline your laundry operation, write today.

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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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Contents

October, 1957 Vol. 34 No. 10

(For subscription rates, see page 106)

Business Manager: Charles A. Edwards
Advertising Manager: Thomas L. Wells
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JUNO

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City ..... Zone ..... Province .....

Notes About People

Lawrence L. Wilson

Appointed to C.H.A. Staff

Dr. D. F. W. Porter, President of the Canadian Hospital Association, has announced the appointment of Lawrence L. Wilson as assistant director in charge of educational programs. Mr. Wilson succeeds Ronald J. C. McQueen who recently resigned to accept an appointment with the firm of hospital consultants, Agnew, Craig and Peckham, Toronto.

Lawrence Wilson, a native of Vancouver, received his Bachelor of Arts degree from the University of British Columbia in 1948. He enrolled in the School of Graduate Studies at the University of British Columbia and did major work in psychology with particular interest in testing and personnel in relation to industry. In 1952 he received his Master of Hospital Administration degree from the University of Minnesota, having completed his administrative residency at Baylor University Hospital, Dallas, Texas. He was appointed junior administrative assistant at the Vancouver General Hospital in July 1952, and thereafter senior administrative assistant and assistant director at the hospital. He was co-ordinator of the course in hospital administration jointly offered by the Vancouver General Hospital and the University of British Columbia.

Mr. Wilson commenced his duties with the Canadian Hospital Association on October 1st, 1957.

General Worthington Retires

Canada's "Mr. Civil Defence", Major-General Worthington, retired September 17th from his post as federal civil defence co-ordinator. His public service in military and civilian fields has totalled 43 years, extending without interruption from the outbreak of World War I, in 1914, to the present time.

Since his retirement from the Armed Forces in 1948, he has shown great steadfastness and devotion to duty. Civil defence officials and volunteers will continue to regard him as the father of civil defence in Canada.

A federal Civil Defence College, established at Arnprior during General Worthington's term of office, is now accepted internationally as one of the finest in the world, and it has graduated more than 8,000 trained civil defence workers.

W. Easson Brown

W. Easson Brown, M.D., assistant East York (Toronto) coroner, and until his retirement in 1956 an anaesthetist on the staff of the Toronto General Hospital and the Department of Anaesthesia, University of Toronto, died in September. In collaboration with Professor George Lucas he did the laboratory work in the discovery of an anaesthetic gas, cyclopropane, and was the first to administer it. In 1923 he was also responsible for the introduction of propylene, an anaesthetic producing insensitivity without loss of consciousness.

B.C.H.I.S. Appointment

Hugh Rodney McGann has accepted a position with the British Columbia Hospital Insurance Service commencing November 1st, 1957. He will be with the Hospital Consultation and Inspection Division.

Mr. McGann has completed the graduate course in hospital administration at the University of Toronto and his administrative residency was taken at the University of Alberta Hospital under the preceptorship of Dr. Angus McGugan. He holds a B.A. degree from the University of British Columbia and has had previous experience in hospitals as a clinical laboratory technologist at Royal Columbian Hospital in New Westminster and at the West Middlesex Hospital in Middlesex, England.

Changes at St. Vincent's Hospital

After 18 years as administrator (and 12 years as superior) of St. Vincent's Hospital, Vancouver, B.C., Sister Mary Ruth has been called upon to be superior and administrator of the new Saint Joseph's Hospital in Saint John, N.B. The original hospital was founded nearly 50 years ago but that will now be used for other purposes in connection with the hospital program. The new building is expected to be formally

Sister Mary Ruth

opened and ready for occupancy some time in the spring of 1958.

The new administrator at St. Vincent's Hospital is Sister M. Loretto, who was in charge of the hospital described above. Sister Superior will be Sister Agnes Marie, x-ray supervisor, who has been at St. Vincent's also for 18 years.

Administrator to Lillooet

Gavin H. Grieve has been appointed administrator at the Lillooet District Hospital succeeding Mrs. William E. Fleming who has resigned. Mr. Grieve was associated with Shaughnessy Hospital, Vancouver, during the past 14 years. Prior to becoming a member of the Shaughnessy staff he was for 17 years in the service of the United Church of Canada.

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Notes About People

(continued from page 12)

Appointments at Royal Inland

Appointments additional to those announced last month for Royal Island Hospital, Kamloops, B.C., include three women in the School of Nursing:

Patricia Bolitho, R.N., of Sault Ste. Marie, Ontario, and a graduate of the McKellar General Hospital, Fort William, Ontario, has been named Clinical Instructor in the School of Nursing.

Mrs. Evangeline Dancer, R.N., a graduate of Vancouver General Hospital, Vancouver, B.C., is appointed Nursing Arts Instructor.

Mrs. Mildred Waddell, R.N., a graduate of the Ottawa Civic Hospital, Ottawa, Ontario, has been appointed Surgical-Clinical Instructor in the School of Nursing.

Ajax-Pickering Hospital

M. Dora Lawrence, a graduate of St. Joseph's General Hospital, Peterborough, Ont., has been appointed as director of nursing at Ajax and Pickering General Hospital, Ajax, Ont. Post-graduate studies include paediatrics at the Hospital for Sick Children, Toronto, and operating room at Medical Centre, Jersey City, U.S.A. Miss Lawrence served at Fergus General Hospital as superintendent and at Niagara Falls as associate director of nursing service.

Administrator Appointed

James A. McMillan, formerly accountant at West Coast General Hospital, Port Alberni, B.C., is the new administrator of Surrey Memorial Hospital, Vancouver, B.C.

Becomes Professor

Bernard R. Blishen, since about 1951 chief of Institutions Section, Health and Welfare Division, Dominion Bureau of Statistics, Ottawa, has resigned to become a professor at University of British Columbia, in the Department of Anthropology and Sociology. Mr. Blishen received a Master of Arts degree from McGill University Montreal, where he majored in sociology. He served with the medical administration branch of the Royal Canadian Navy, from 1938 to 1945, and with the Public Health Section of the Dominion Bureau of Statistics.

New to Royal Victoria Hospital

Formation of a sub-department of cardiac surgery at Royal Victoria Hospital, Montreal, under internationally known heart surgeon Dr. Arthur Vineberg was announced recently. Dr. Vineberg has been named surgeon-in-charge of the new department and promoted to associate surgeon of the hospital.

Dr. David Murphy, surgeon-in-chief of the Montreal Children's Hospital, has been appointed honorary consultant to the Royal Victoria Hospital and will be associated with the new sub-department.

Honoured by French Government

Dr. Max Thorek, Chicago surgeon and founder of the International College of Surgeons, has been honoured by the French Government with the award of Commander of the Legion of Honour for his important contributions to surgery and his outstanding work in the formation and growth of the College, "creating a better understanding and scientific co-operation among surgeons of the world."

Since the college was founded 22 years ago at Geneva, Switzer-

(continued on page 28)

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SYMBOL OF QUALITY *Beiersdorf*

Notes About People

(continued from page 24)

land, it has established chapters in 42 countries, excluding Russia and its satellites, and has a membership of 12,000 surgeons.

Dr. Thorek is responsible for the idea of an International Surgeons' Hall of Fame, which became a four-storey museum housing surgical memorabilia of the world, combined with a School of History of Surgery and its related sciences, established adjacent to the college headquarters in Chicago. He also is president and chief surgeon of the American Hospital, which he founded.

Pharmacy Graduate Takes Administrative Post

William Beatty, who completed residency at Kingston General Hospital this year, has been appointed Administrative Assistant at the Ottawa Civic Hospital, Ottawa, Ont. Mr. Beatty is a 1957 graduate of the University of Toronto course in hospital administration. He holds the degree of Bachelor of Science in Pharmacy and was formerly pharmacist, lecturer, and laboratory director at Maritime College of Pharmacy, Halifax, N.S.

American Award for Service

John H. Hayes, hospital consultant of Douglaston, N.Y., has received the 1957 Distinguished Service Award of the American Hospital Association. This is the highest honour conferred by the Association. It is for outstanding leadership in hospital administration.

Named Business Manager

Geoffrey C. Rogers, accountant for the past 16 months at Women's College Hospital, Toronto, and formerly deputy finance officer for a group of hospitals in Essex County, England, has been appointed as business manager for Swift Current Union Hospital, Swift Current, Sask.

Changes at Nipigon

Jean Patterson, R.N., who has been superintendent of the Nipigon District Memorial Hospital since its operation was taken over in January 1956, left recently for Brandon, Manitoba, where she will make her home. Mrs. Gladys Gordon, of Nipigon, has succeeded Miss Patterson, as superintendent. Irma McTavish is now office manager, succeeding Mrs. Bertha Oja who has moved to Atikokan, and she is assisted by Susan Swanton of Red Rock, Ont.

Study Hospital Insurance

Cecil Kennedy, a graduate of the diploma course in hospital administration, University of Toronto, has been appointed executive officer of the Nova Scotia Hospital Service Planning Commission. The commission which is under the provincial department of health is charged with study and research in connection with hospital insurance. Mr. Kennedy was formerly assistant administrator of the Nova Scotia Sanatorium at Kings County, N.S.

Change in Administratorship

Sister Marie Jeanne Tougas, R.N., has been transferred as administrator of La Verendrye Hospital, Fort Frances, Ont., to the Regina Grey Nuns' Hospital,

(concluded on page 106)

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Asiatic Influenza

CASES of Asiatic Influenza have been positively identified in Canada in at least four provinces, British Columbia, Alberta, Ontario, and Quebec. This particular strain of influenza so far has been very mild. The typical course is for the disease to last three or four days, with the patient incapacitated for approximately one week. A feature of the disease is its tendency to spread rapidly through a community. It may reach epidemic proportions, with some 15 to 20 per cent of the population being affected. Under such circumstances, this can cause a disruption of essential services, and if that percentage of hospital personnel should be affected in any hospital, provision of adequate patient care becomes difficult.

While all indications at present are that this particular type of influenza has a very low death rate there is, of course, concern that as the disease becomes more wide spread in the population, the virus which is responsible may change its characteristics. The future course of the disease cannot be predicted with any degree of certainty and has to be watched closely over a period of time.

The production of a vaccine to combat this particular strain of influenza has been the subject of negotiation between the Federal Department of Health and Provincial Departments. It is expected that some 600,000 doses of the vaccine will be available by the end of the year and somewhat double that amount by March 31, 1958. Officers of the Department of National Health and Welfare are also testing American-produced vaccine.

It is recognized that influenza vaccine is only of value where the particular strains of the virus ocurring in the epidemic are similar to those used in the vaccine. This explains why supplies are limited in quantity at the present time. Supplies of vaccine are being prepared at the Connaught Medical Research Laboratories of the University of Toronto and at the Institute of Microbiology, University of Montreal. However, the quantity available is limited and will not be sufficient to cover the general population. The distribution of the vaccine will be handled by the Department of Health in each province. It is not expected to cover more than those who are most exposed and whose services are essential in the care of others, such as physicians, hospital staff, and transportation workers. It is also to be remembered that protection extended by the vaccine cannot be expected until some 10 to 14 days after its administration.

The Long-stay Patient

A SURVEY made in the United States in 1955 showed that only 14 per cent of the services and facilities required for long-term patients were available. There is every reason to believe that the same situation exists in Canada. Increase in life expectancy, from 49 years in 1900 to 68 years in 1950, which is largely the result of applying medical research, is associated with a decline in infectious diseases. On the other hand, there is growing incidence of chronic diseases and illnesses that affect especially the older members of the population. It has been estimated that about 20 per cent of patients in the average general hospital are chronically ill.

While many health workers have stated that chronic illness is the nation's No. 1 health problem, only a few communities have given it much thought. Some of this inertia is due to not clearly defining what is meant by "chronic illness". The term "chronic" is confused frequently with "convalescent" and too often it is assumed that the label "chronic" adequately delineates all long-stay patients.

There are many types of chronic illness and various

categories require different methods of handling. With reference to the general hospital it is contended that too many beds for the acutely ill are occupied by patients suffering from chronic conditions. This statement is too general to cover the rather complex situation. There are at least three broad categories of long-term patients at present occupying general hospital beds. One group requires the services of the general hospital to ensure adequate diagnostic and treatment facilities. The second group needs skilled nursing care and the third, domiciliary care. When one hears the statement that more "chronic" hospital beds should be provided to relieve pressure on the "acute" beds, it usually applies to the latter two groups.

For the wide range of chronic illness, a variety of institutional services is required. Under current practices these are provided in varying degrees by the general hospital, the chronic disease hospital, mental and tuberculosis hospitals, special rehabilitation institutions, nursing and convalescent homes, and homes for the aged.

Some long-term patients require, at least for a considerable period, the facilities of the acute general hospital, some require the facilities of the long-term hospital and others are best treated in their own home or, if they do not have a home of their own, a foster home. All of these institutions in a community ought to be organized to provide ready liaison between them and agencies concerned with these patients. In seeking this liaison, the general hospital should take the leadership. What one general hospital has been able to accomplish in this direction is outlined in "A Program of Integrated Medical Care", in the September issue of *The Canadian Hospital*.

The degenerative diseases—heart diseases, cancer, diabetes, kidney disease, neurological disorders—and accidents, are the great maimers and the great killers of our time. It is with these we must contend. The question "Should the general hospital provide the necessary hospital care for patients with chronic illness?" is academic. More and more, the general hospital is being faced with the complex medical and social problems of such patients. The advances of medical science which have helped produce the problem also make it possible for the general hospital to be more effective in the rehabilitation of patients with long-term illness. Fifty years ago, because the primary need was to meet requirements of patients who were acutely and dramatically ill, and since little could be done for patients with chronic illnesses, this kind of care was not offered.

One of the objectives of the National Health Program is to encourage, through larger grants, provision of more accommodation for chronic and convalescent patients, in order to free the active treatment beds. In spite of the extra premium of $500 given for the construction of space for the chronically ill, the number of new beds provided has been disappointing.

Yet the answer to the problem of the long-term patient is not only a matter of accommodation. The turn-over of the long-term patients is slow and, with the increasing life span, the additional beds provided soon become occupied and we are back to where we started. What is needed is a community approach to the problem and the recognition that it can only be solved when all health agencies work together.

Perhaps it was not the initial cost of construction which communities found too burdensome to provide. It was probably the question of how these institutions were to be financed after they were in operation. Under Bill 320 of the proposed national hospital insurance program, care of chronically ill patients will be covered. This will undoubtedly encourage many communities to provide this type of care.

In recent years there has been considerable discussion about the need to raise the standard of care for chronic illness. One aspect is medical supervision. Every institution giving care to long-term patients has a responsibility to ensure that all patients have adequate medical care, including complete examination on admission and periodic evaluation. There is also a need for facilitating transfer from one type of institution to another, according to the specific need of the patient. Co-operative arrangements should extend to community health agencies involved in home care.

General hospitals are in the key position to assume leadership in these expanding fields of health care. One rôle of the general hospital is to serve as a screening centre where the type of attention needed by each patient is determined — active treatment, chronic care, rehabilitation, or nursing home care. Co-ordination of all local and governmental health and welfare agencies is essential if chronic and rehabilitation needs are to be met.

A Hospital is Born

THE birth of a hospital is a phenomenon that is infrequently observed and less frequently recorded. The Children's Hospital of Winnipeg moved in the space of a few hours into a completely new building and its life began anew. At first, patients and staff were filled with wonder. Personnel took themselves on unnecessary journeys to the far corners of the building to satisfy their curiosity. All was beauty and precision.

Then the mood changed. This was not Utopia. There were limitations and difficulties. New methods failed to work and the familiar methods of the old hospital were even less effective. Department heads failed to remember that they were working in areas that they or their predecessors had helped design a couple of years before. Some of them tried to rebuild and relocate their facilities, quite unaware that they were in reality attempting to recreate their old department as it was in the building they had left. Disenchantment crept in.

To counter this a period of hard driving work began on the part of everyone. Lights burned late as procedures were rewritten, organizational patterns were revised and methods were changed, time after time, to include tag ends that invariably were left over. Determinedly it went on even though the reworked plans were surprisingly like the old. Gradually the heads of departments and services began to apply their paper plans of months before to the reality of the building.

Suddenly it happened. There was a new atmosphere in the wards. It was the same in the kitchens, the C.S.R., the laundry, everywhere. The hospital was alive—it was working. What had taken hard slugging was now accomplished with quiet efficiency. The building responded to the staff and they to it. Morale began to rise and the never-ending demands to chop and change ceased. The effectiveness of the staff increased spectacularly as the building proved itself and demands for additional staff melted away. A hospital had been born.—*J. E. Robinson.*

Winnipeg Children's Hospital

history
lay-out
nursing
out-patients
surgery
records
therapies
dietetics
laboratories

FIFTY years ago a young, unmarried immigrant girl, friendless and unversed in the English language, was in the throes of despair as she watched the life ebb from her sick child. Mrs. Annie A. Bond, a kindly English woman, was informed of this pitiful situation and promptly took the child into her own home where she brought it through its illness.

Thus was laid the foundation and tradition of Children's Hospital.

Mrs. Bond was a trained nurse with a wealth of experience in the Florence Nightingale tradition. As one of the first ten nursing sisters in the Royal Army Medical Corps, she had served in the Zulu War, the Second Afghan War and the Egyptian Campaign.

When the fighting ended, this quiet unassuming nurse, who had developed a lasting sympathy for the distress of others, emigrated from her native England to New Zealand, where she established that country's first school of nursing. In 1886 she married Dr. J. H. R. Bond, an Auckland Hospital physician, and later journeyed to the United States, and then to Winnipeg, in 1893, for permanent residence.

The first forlorn child was but one of many which found its way into Mrs. Bond's home. The procession of patients grew from one season to the next. Annie Bond was equal to the challenge but she also came to a perceptive conclusion: Winnipeg needed a children's hospital.

With this in mind, Mrs. Bond went to work. She tackled the local National Council of Women and fired them with enthusiasm for the idea. The ladies formed guilds, held bazaars, sold paper flowers and ran teashops. In countless ways they raised money. By 1909 they had sufficient funds to purchase a near-derelict house and convert it into a hospital for children. It opened humbly with one nurse, one patient and one chair. The roof leaked and the woodshed formed the out-patient department. However, the staff made light of the obstacles and found pleasure and pride in treating small patients.

At the same time, bigger plans were being formulated. In 1911 a campaign was launched for funds with which to build a proper hospital. The public responded generously and one year later Children's Hospital was erected on Aberdeen Avenue near the banks of the Red River. It has been a leading light in the treatment of sick children ever since.

The fame of this white frame building soon spread. It was, and is to-day, the only hospital of its kind in Canada between Toronto and Vancouver.

The Children's Hospital of Winnipeg. Architects: Moody and Moore, Winnipeg, Manitoba.

It became a general hospital in the true sense of the word, concerned not only with the treatment of patients but also with the training of doctors and nurses and the furthering of medical research.

Children's has developed many hospital "specialties" such as a "squint clinic" for children with eye disorders, a "speech clinic" and a "play therapy clinic" for emotionally-disturbed youngsters.

Some minor additions were made to the original building after 1911 but there had been no construction at all for more than 24 years. The hospital, built to accommodate 60 beds, had more than 120 beds and cribs crammed into existing facilities during recent years.

With the many advancements in medicine and surgery more space was required and as a result of two campaigns for voluntary support the new Children's Hospital was built and was officially opened on December 2nd, 1956. The hospital provides accommodation for 250 children in surroundings that are both beautiful and effective. The building was financed entirely through the generosity of the citizens of Greater Winnipeg and Manitoba, together with federal and provincial government grants. It is a voluntary, non-profit corporation, open to all children regardless of race, colour or creed. It is a hospital with a modest past but an unlimited future in which it intends to take its place along with the great paediatric institutions of America.—*J. E. Robinson, Superintendent.*

In this series the names of authors appear at the end of each section.

purpose and facilities

THE Children's Hospital of Winnipeg is a 250-bed institution planned and designed not only for the care of the acutely ill child, but also for the infant or child handicapped by poor vision, faulty hearing, cerebral palsy, diabetes, poliomyelitis, allergy, mental retardation and emotional maladjustment. The construction is such that changes in utilization of available space may be made to keep up with changing trends in the practice of paediatrics. The present emphasis on childhood surgery, home care of all but the extremely ill child, and investigation of retarded and emotionally disturbed children, is reflected in the space made available for out-patient care, mental health and physiotherapy and operating area. The Poison Control Centre for Manitoba is located in the casualty area of the hospital. Some 200 cases of accidental poisoning are dealt with each year in the casualty department.

To cope with the increasing incidence of severe respiratory infections, many due to viruses, two "high humidity" rooms have been built. These are designed to furnish an atmosphere of high humidity at any desired temperature. Infants or children in these rooms require no "tents" or "croupettes". There is a freedom from the fear of confinement in enclosed spaces. Nursing care, feeding, treatments, examinations, and even visiting are all simple to manage. It is hoped that the use of these rooms for selected cases may result in more rapid recovery from these distressing illnesses and may obviate in some instances, the need for tracheotomy.

Rules are laid down for visiting as they are in all hospitals, but a reasonable amount of flexibility is permitted in interpretation of these rules. Extra visiting is permitted where it is considered to be of advantage to the infant or child. Rooms are available in each floor for "rooming in" where it is considered wiser not to separate parent and child.

Teaching and research complement patient care in carrying out the responsibilities of a children's hospital. The Children's Hospital is a major teaching unit of the Facul-

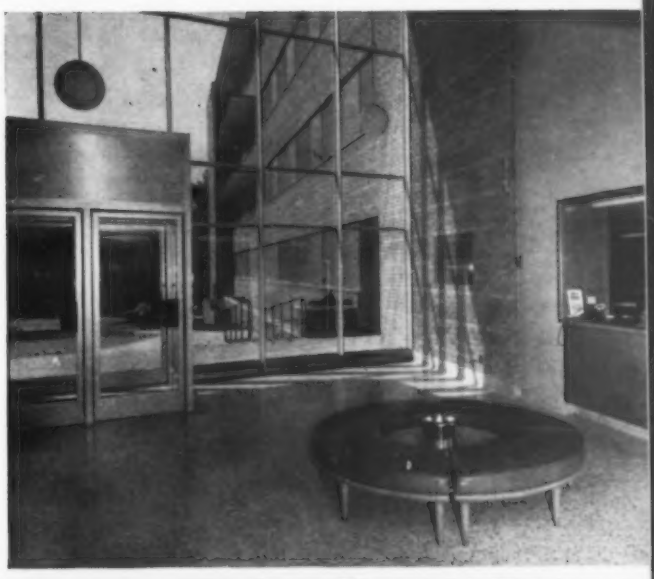
ty of Medicine of the University of Manitoba and the Professor of Paediatrics is also Paediatrician-in-Chief of the hospital. Undergraduate medical students and nurses receive their paediatric training here. A full program of residency training continues throughout the year for an increasingly large group of graduate medical students proceeding to certification or fellowship training in paediatrics. In addition, annual post-graduate meetings are held for general practitioners and for public health physicians.

The intern staff totals 20 and includes a chief resident, resident in surgery, resident in psychiatry, resident in pathology, two assistant chief residents, and seven senior residents, all in process of certification or fellowship training. In addition, rotating post-graduate interns from the Winnipeg General and St. Boniface Hospitals, spend two months of training at the Children's Hospital.

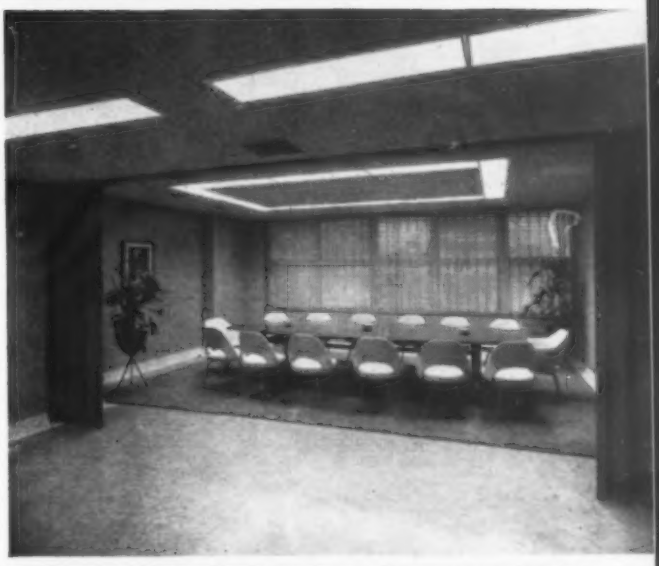
The research program of the Children's Hospital has so far consisted of investigation of blood group incompatibilities and erythroblastosis, under the direction of Dr. Bruce Chown. Under his supervision, three members of the hospital staff attend to all emergency care of erythroblastotic infants in the Winnipeg area. Clinical research in prevention of death in the newborn period is being carried out by Dr. J. N. Briggs, and Dr. David Grewar is studying the fate of 1,000 prematures born at the Women's Pavilion of the Winnipeg General Hospital since May 1950. Dr. Sydney Israels is continuing his investigation into newer diagnostic methods as applied to diseases of malabsorption. A program of basic paediatric research is now in the planning stage in the fields of bacteriology, haematology and metabolism.
—Harry Medovy, M.D., Paediatrician-in-Chief.

hospital lay-out

THE structure of the building is of reinforced concrete with a caisson foundation reaching some 60 feet below normal grade. The basement walls are of solid concrete, to the ground floor window sill level, insulated through the ground floor level with one inch of cork. The basement floors are laid on gravel fill and the subsequent floor structures are of joist



Main lobby



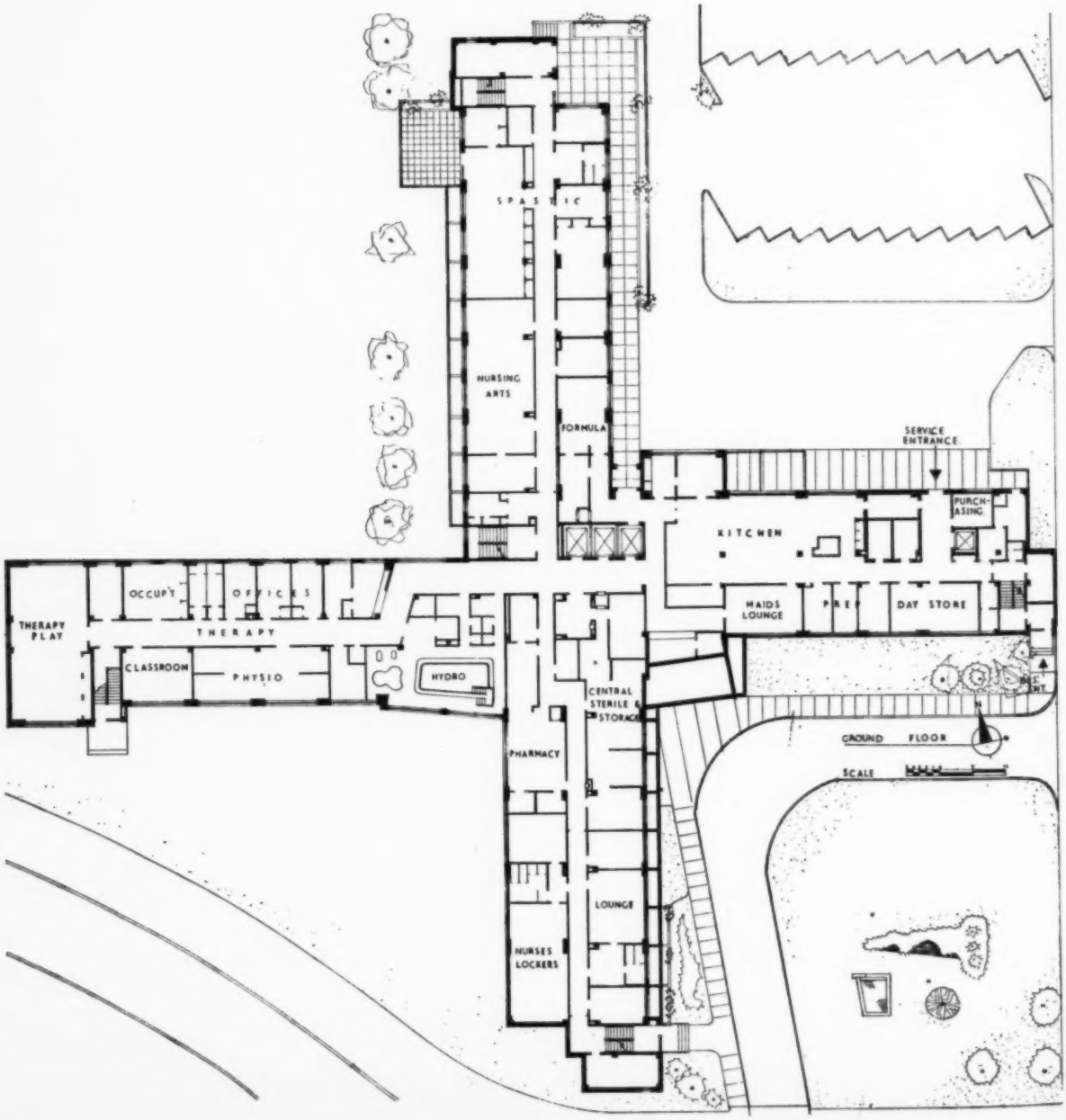
Board room

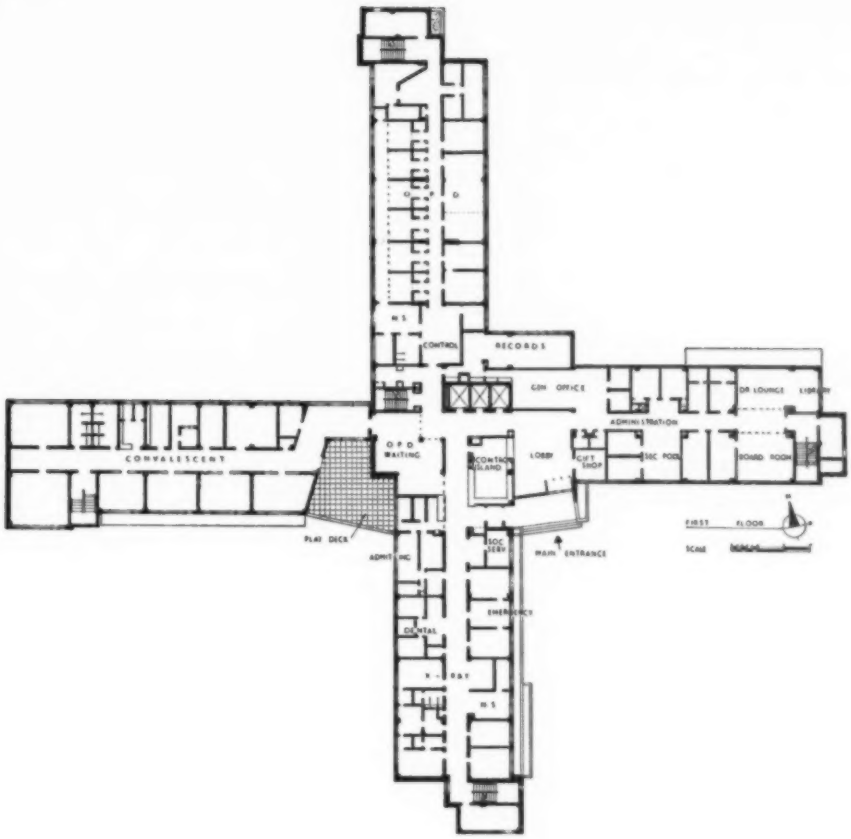
Doctors' lounge and library

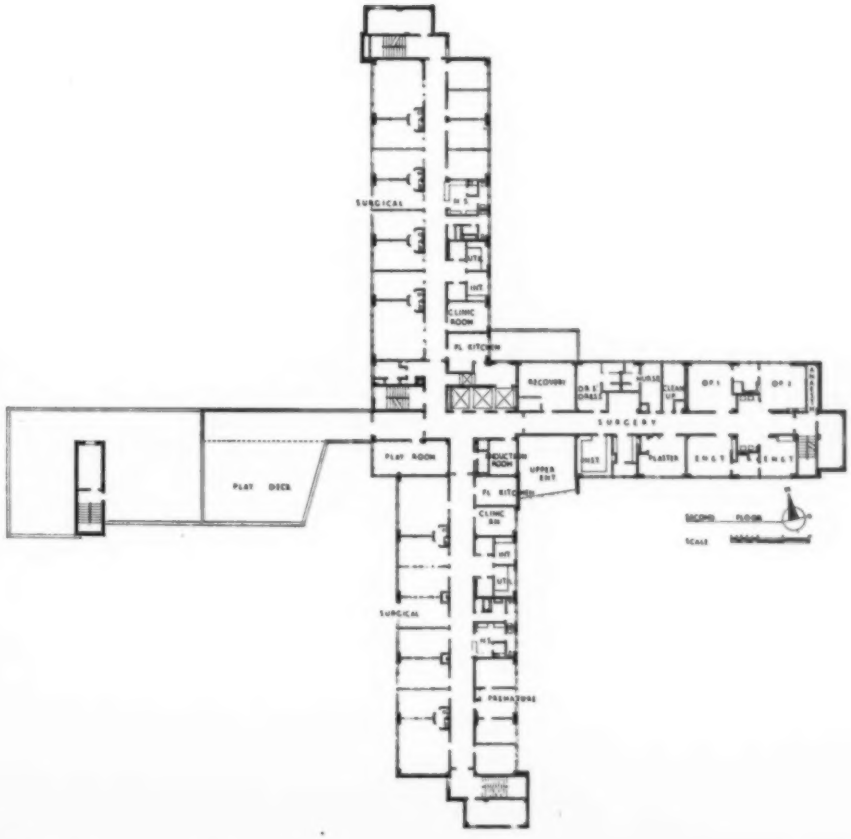
construction using removable steel forms. The corridor floors are framed in a six-inch reinforced slab and the perimeter spans are of ten-inch joists and two-inch slab construction. The entire building is reinforced to provide for a future two-storey addition. The dining room section on the fourth floor, east wing, is of structural steel construction, so that in the event of upward expansion in this wing, the dining room may be dismantled and replaced on the upper level once more.

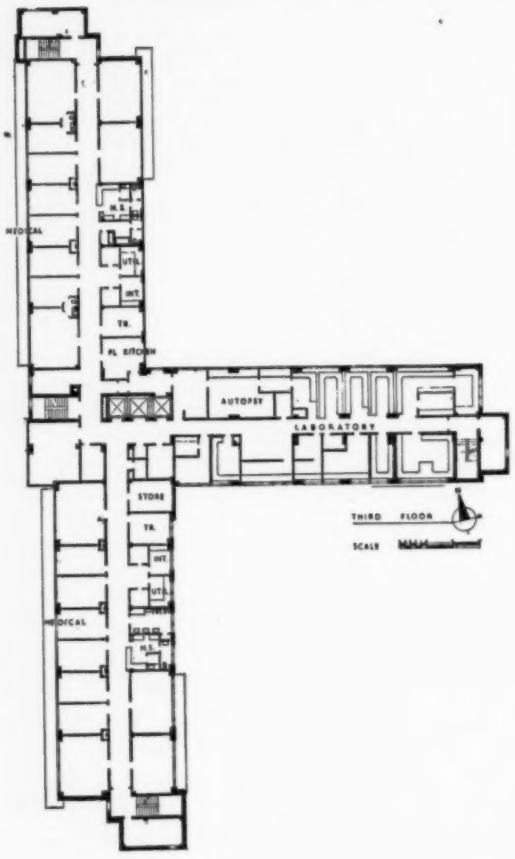
The general wall construction above the ground floor sill level is of perlite block with brick veneer. The eight-inch perlite block plus four inches of brick produces a wall with a heat resistance equivalent to one constructed of 12 inches of brick insulated with one inch of cork on the interior—at a considerable saving in cost, labour and weight. The perlite block is plastered directly on the inside face. The concrete frame is insulated throughout with a one-inch thickness of cork to bring its insulation value to equal that of the wall. The roofs are insulated with cork, two inches thick under the built-up roofing.

The windows throughout are double-glazed and every window in the building is an operating window of one of three different types. At the basement and ground floor levels, the windows are of the inward projecting type of sash. On the first floor and above to the lower penthouse level, the windows are of a special type which are inward projecting, reversible sash, which rotate completely in such a way that each may be cleaned from within the room. The large ward




CONVALESCENT
RECORDS
CONTROL
G.O.H. OFFICE
DR. LOUNGE
LIBRARY
ADMINISTRATION
O.P.D. WAITING
CONTROL ISLAND
LOBBY
GIFT SHOP
SOC. SERV.
BOARD ROOM
PLAY DECK
ADMITTING
MAIN ENTRANCE
FIRST FLOOR
SCALE
EMERGENCY
DENTAL
X-RAY

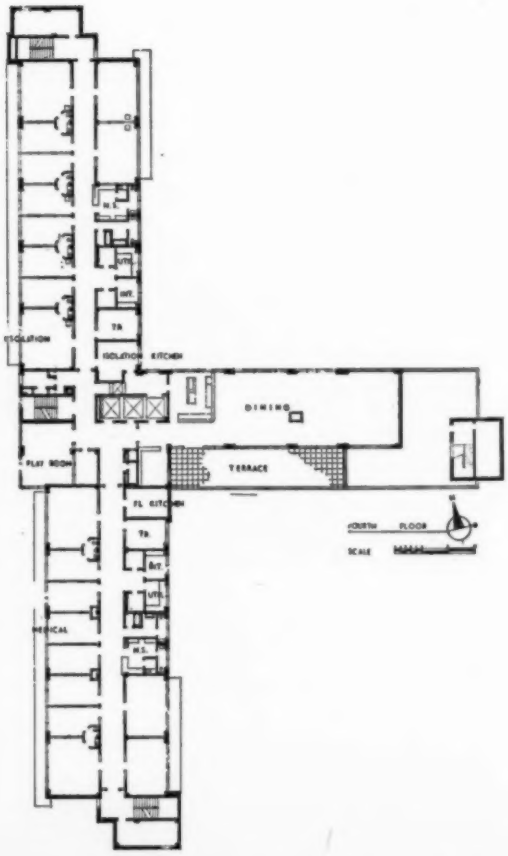

SURGICAL
CLINIC ROOM
FL. KITCHEN
RECOVERY
DR'S LOUNGE
NURSE
CLEAN UP
OP. 1
OP. 2
SURGERY
PLAY DECK
PLAY ROOM
INJECTION ROOM
UPPER ENT
INST.
PLASTER
ENT.
ENT.
FL. KITCHEN
CLINIC RM.
SURGICAL
PREMATURE
SECOND FLOOR
SCALE



windows are of a pivoted type which may be completely rotated top for bottom for ease in cleaning. These large windows are on janitor locks, while the others are operable for ventilation. All windows are kalemeined with stainless steel on the exterior, and painted wood finish on the interior. All ventilation windows are screened with aluminum-framed fibre glass screens. The method of double glazing is with sull sash glazing for the interior glass and putty-set kalemeined wood glass stops on the outside of the 2¼ in. thick sash. A 4 in. thick concrete canopy extends four feet from the building to shade the ward windows on the south, east, and west elevations.

The partitions are generally of clay tile plastered on both sides and in the lavatories and bath rooms they are faced with ceramic tiles. Floor coverings generally are of linoleum with terrazzo base or terrazzo. The feature of the wards is the glazed partitions which permit supervision throughout the length of the wards, greatly facilitating nursing, and the spread of daylight. The airy, daylight effect is heightened by the liberal use of colour.

All stairs are of concrete construction and are located at the end of each wing, with one in the centre which, with the elevators, is framed in solid concrete, forming the wind bracing which was required. There are three elevators, two passenger and one service, with a framing provision for a third passenger elevator should that prove necessary. A freight lift is located in the kitchen wing, near the delivery entrance, to serve the storage wing directly below. Two dumb-waiters, one serving the central stores, and the other the kitchen, and the formula room, and the floor kitchens, are included. An automatic pneumatic tube system, connecting 13 points in the hospital, speeds samples, records and medicines through two loops in the building, being switched to the right locations by magnetic impulses from the carrier itself. The system is completely concealed in the ceilings and walls and it has its nerve centre in the second level



penthouse, which space it shares with the automatic exchange of the telephone system and the elevator machine room.

At the extremity of each wing on each floor is a fan room which houses the ventilation system for that wing. Units in this room supply fresh heated air through trunk ducts running down the corridors and into the rooms on either side of the corridors. This air is exhausted by means of exhaust ducts in the corridors and out the ends of the wings through a louvered grille which runs the height of the building at the fan room's outside wall. The operating room wing is the only part of the hospital which is air conditioned in the normal sense of the word. This portion of the building is temperature and humidity controlled. Steam for heating is provided from a nearby steam plant operated by the Winnipeg General Hospital. The normal heating system of convectors along the outside wall is employed as the major heat source and the fresh air is heated to compensate for winter temperatures.

The main entrance to the hospital is two storeys high and is glazed with thermal glass through the two storeys. On the opposite side to the entrance of the north-south wings is a four-storey curtain wall bay-window with spandrel infills of glazed ceramic tile arranged in a colourful abstract pattern. This encloses the playrooms on each floor and overlooks the play decks on the first floor and the roof of the convalescent wing. These play decks are paved with precast concrete paving blocks as is the dining room terrace and the interns' terrace on the first penthouse level or roof level.

Lighting throughout the hospital is mainly fluorescent with a high intensity of light in most areas. The overbed lights are specially constructed for the purpose and are integrated into the dividing partitions between rooms of the nursing wards. An upward component provides general room illumination and is controlled from the corridor. The downward component is for reading or examination and is controlled from the interior of the room at the bed side. The nurses' call system is integrated with a listen-call intercom set at the nurses' station, by which means the nurse may check each room for noise or instruction and issue instructions. A paging system is installed which can be utilized to pipe music throughout the entire hospital in the corridors and some of the rooms, in addition to calling personnel.

The transformer vault in the basement is connected to two power stations by means of an automatic throw-over switch. In the event of a power failure by one station to which the hospital may be connected, the switch automatically throws the hospital over to the other power station resuming automatically the flow of power. The standard emergency standby power system is thus eliminated.

Construction Costs

Total cost of hospital	$2,375,000.00
Cost per bed	$9,900.00
Cost per square foot	$18.55
Cost per cubic foot	$1.76
Cost of equipment and furnishings	$540,000.00
Number of beds	240
Total square feet	128,000
Square feet per bed	535
Total cubic feet	1,346,360
Cubic feet per bed	5,610

These are but the descriptions of the skin, bones and nervous system of a complex organism. The hospital was laid out in the interior around a principle of operation, to reduce the confusion and time needed to care for the sick efficiently from birth to sixteen years of age. The operation is proving itself to justify the care exercised in the initial planning. It was a great source of pleasure to see the "skin and bones" take life with the arrival of convoys of ambulances from the old hospital bringing the life blood of the new one, causing its birth and emergence as a complete whole—*Moody and Moore, Architects.*

effective colour

COLOUR choices for the Children's Hospital were made with three groups of people in mind. First, and of prime importance, are the children who are patients. Whether in-patients or out-patients, these children should be made to feel as happy as possible. The visual impact of a hospital can do much to dispel the fear that surrounds a child when he is first brought into the strange environment of a big institution. One element that is all-important in this visual impact is colour. But for colour to be effective, it must be colour appealing to children — bright, light, clear, simple, uncomplicated. It must have a wide range to give the excitement and anticipation associated with children and it must be in areas of a size children can comprehend. Here at "Children's" the whole rainbow of colours has been used. However, care was exercised to ensure that the lightness and brightness of the different colours were the same, thereby giving the whole scheme unity and coherence. In order to reduce the corridors to more child-like proportions, the panels under the windows between corridor and wards were painted a series of six intense colours, giving the corridor the appearance of an aisle between rows of toy building blocks. Unity and order are maintained by the warm beige linoleum floor and the white ceilings. Because the wards are interconnected visually by glazed partitions, blocks of wards were treated similarly keeping the colour the same throughout each group, but changing the tint and shade. Generally speaking only two colours were used but lighter and darker values of the same colours give definition to ceilings, windows (exterior), walls, and toy shelves. The cubicle curtains are light but more muted (grayed) in colour to be less obtrusive when drawn so that they do not give a shut-in feeling. In a hospital colour scheme allowance must be made for the large areas of white—the sheets and counterpanes of the beds. The ward floors were kept bright and colourful so that the shadow areas under the furniture would not become dark and oppressive.

So much for the patients. What about the people who work in a hospital? This is their office, factory, laboratory. They do not need the same stimulus and gay, carefree atmosphere that surrounds the children. They need quieter colour, richer and more subtle, closer harmonies but with considerable variation. Many of their duties require a high degree of concentration which often is nervously exhausting both visually and because of the pressures of time and restricted movement. Therefore, colours deeper in tone, not so intense (grayer) were chosen, although a wide range of colours was maintained. Soft reseda greens, brownish beiges, grayed sand, turquoise, and grays with a purplish cast were used for interview areas, consultation and private offices, general offices, record areas, nurses' stations and locker and staff lounge areas. The exception to this more muted scheme is in washroom and toilet rooms where the plumbing fixtures and wall tiles are stark white with

Out-patient waiting room

a very intense coral upper wall and ceiling in the women's room, and a bright fire-engine red in the men's.

Operating areas were tiled and painted a light so-called "eye-ease" green since experience has shown this colour to be most satisfactory where visual concentration is so great. One modification was made, however; the green of the walls is lighter than is usually used and the tile is a matte finish. This reduces the contrast between the highly illuminated operating area and the outer fringe areas. The matte finish tends to reduce glare and the unpleasant highlights of glazed tile surfaces. All diet kitchens were painted a clear sunlight yellow above white tiled dadoes. (Here a word of warning about yellow. The author has never had success with any yellows except those derived from the pigment chrome yellow, *light*. Other chrome yellows, regardless of what your painter says, will produce strong, eggy yellows that do not belong in any colour scheme. Other yellows are dangerous to use and if you want *yellow* never expect such pigments as yellow ochre or raw sienna to give you light, clean, clear yellows.) Utility areas including fan rooms, storage rooms, stair halls, storage areas, were all treated in a light clear tan, both walls and ceiling. This was an economy measure which permitted the use of spray equipment for maintenance without the necessity of masking various areas.

The third group of people to be considered falls between the first two. Included are the parents of children who are patients in the hospital and the "public" or friends of the hospital from whom the hospital derives much of its support both service-wise and financially. These people see and work in nearly all areas of the hospital. If their children enter a gay, light-hearted ward where they, the children, are happy and if the business and work areas of the hospital look efficient and friendly, the hospital has solved one of its most difficult problems—how to win the parents' confidence so that the staff's attention may be devoted more fully to the child.

Colour is one of the most efficient tools with which to establish harmony and co-ordination in a hospital. A happy child is an easier patient to deal with. A happier patient means a happier and more efficient nursing and medical staff. Pleasant surroundings make a more contented maid, a better cook. Pleasant surroundings help build a sense of pride, encourage support and make the job easier.—*Prof. D. Dunklee (Moody and Moore, Architects).*

nursing care

THERE are seven wards in the hospital, six of which are designed alike, while the seventh, intended for convalescent patients, has a slightly different structure.

The six similar wards, situated on the second, third and fourth floors of the north and south wings, are divided into two, three and five-bed rooms on one side of the corridor, while the other side, in addition to patient rooms, has the nurses' station, clinic room, bathroom, dressing room, kitchen (shared by two wards) on the north wing and utility areas. Partitions of glass separate the rooms, though these have curtains which can be drawn at any time for privacy. There are also windows from the corridor into all rooms for easy observation. Floors of the patients' rooms, the corridor and kitchen have linoleum, while those of the nurses' station and utility areas are terrazzo. All have terrazzo borders rounded to the wall for easy cleaning. The corridor has acoustic ceiling tile.

The rooms designed for older children have cubicle curtains, as have some of the baby rooms. In most rooms, however, beds and cribs are interchangeable, the exception being the three-crib rooms which can accommodate only two beds with ease. All the beds are adjustable for all positions. The cribs also can be raised for bedmaking. They have high sides with bars 2¾ inches apart. Two cranks make it possible to raise either head or foot as needed. Beds and cribs are standard throughout the hospital.

Bedside tables are large and have four drawers. The top one, the largest, is intended for the child's toys, or, in the case of smaller infants, any special trays. The second and third drawers contain wash basin, toilet equipment and bath blanket. The bottom drawer which is divided contains bed pan, urinal and shoes. The tables have casters and are moved easily.

All patient rooms have washbasins with wrist operated taps and in some wards there is a small lavatory between two rooms.

Thermometer racks for individual thermometers are placed above the washbasins. In infant rooms there is a diaper can near the sink.

A communication system from patients' rooms to the nurses' station makes it possible for the nurse to speak to patients from the desk

and also to "listen in" on the rooms if necessary.

Oxygen and suction outlets are placed in some patients' rooms throughout the hospital, except on the convalescent ward.

The nurses' station is situated half way along the ward corridor from which it is separated by a counter-topped partition. Desk-high counters are on three sides of the area. A small medicine room and wash room are on the exterior wall side. Drawer space is provided under the counter and in two pedestal supports. One wall contains a window to patient rooms and the other contains the chart rack and bookshelves. Each station has two posture chairs and four stools.

The tube station is situated in the nurses' station and messages and requisitions are thus easily transferred from one department to another.

There are two small bathrooms on most wards, the tubs being raised to waist height.

An interns' office provides an interview area for patients and is equipped with a desk, chairs, cupboards, dictaphone and telephone.

Linen rooms have shelves on one wall only, leaving most of the floor area for parking space for linen wagons which come directly from the laundry with bed linen and clothes sorted into pigeon holes. This wagon is used for distribution of linen to patient areas thus eliminating any folding and piling of linen on the ward. The linen room shelves are used for extra blankets, pillows, et cetera.

The utility room contains a hopper for the disposal of fluid wastes and shelves for equipment awaiting return to central supply.

In the central area of the hospital, between two wards, there is a play room on each floor furnished with a television set and both normal size and miniature furniture. One interesting item is a dwarf size chesterfield and chair set with pale green plastic cover. Shelves hold an assortment of books and toys.

A waiting room for parents and visitors is provided next to the play room. A janitor's closet, garbage and linen chutes are also situated in the central area, as well as two dumb-waiters, one from the kitchen and one from central supply.

Several wards have special features or areas devoted to a specific type of patient. For example, at one end of the "clean" baby ward

Nurses' station

is situated the premature unit (described separately). Another ward has two two-bed rooms equipped with high humidity units, one of which has been in almost constant use since we moved.

The ward intended for infectious diseases has additional features such as cupboards in the corridor for storage of gowns, a bed pan washer-sterilizer, and an autoclave in the utility room. This autoclave is double-ended. The contaminated articles are placed in it in the utility room and removed sterilized in the dressing room. All wash basins in patient areas on the ward are equipped with foot pedals and the water outlet is raised well above the basin to permit adequate hand washing. Hexachlorophene soap is used for hand washing, both on this ward and throughout the hospital.

This ward also has its own kit-

Central sterile supply

chen, with a dishwashing machine and garburator.

The convalescent ward on the first floor is similar in general layout but has only one two-bed room and does not have glass partitions or cubicle curtaining. The bathrooms, separated for boys and girls, each have two larger tubs and a lavatory. There is also a larger utility room with plenty of cupboard space, hopper, et cetera. A special feature is a dining room with standard and small tables and chairs adjacent to a small kitchen. This room also has a television set. At one end of the ward is a patio where children play under supervision in good weather. At the other end, stairs lead down to the main play room.

The colour design throughout the hospital is one of its most pleasing features. Walls are mostly pastels, with the occasional stronger colour in darker and utility areas. Along the ward corridors panels of strong colours beneath the corridor windows break the neutral line and add a focus of interest.

Chairs in the wards have black metal frames with brass coloured "harp string" backs and pastel shaded soft covered seats. Some rooms also have matching armchairs.

Window curtains are of materials of varied patterns selected to carry out colour schemes and at the same time add a touch of individuality to each area. Partition and cubicle curtains are of solid pastel colours.

On each ward there is a two-bed room intended for clinic use. These are equipped with x-ray view boxes and chalk boards. At present, until the hospital is fully opened (student nurses are living on two wards), these are being used for patient accommodation.

A conference room on the ground floor is shared by doctors and nurses and is used for lectures, student and staff education programs, staff meetings, and clinics.

The offices of the nursing department are in the main administrative area on the first floor readily accessible to the administration, medical staff and the public.

The Premature and Newborn Unit

The premature and newborn unit is set up to accommodate ten patients. There are two nurseries, each 15 feet by ten feet, ten inches, which allows the required minimum of 30 square feet for each patient. Although the nurseries are not air-conditioned they are equipped with an air-filtered blower system which provides for adequate draft-free ventilation.

Each nursery is equipped with a scrub-up sink with foot pedal control, a foot controlled germicidal soap dispenser and paper towel dispenser for convenient and efficient hand washing technique.

The nurseries are glazed on all sides allowing for easy observation and viewing, by visitors.

The incubator used here has forced-air circulation, air being drawn from the outdoors to prevent cross infection. Provision has also been made for the recommended venting of the incubator to the outdoors.

Each patient unit is provided with a bedside locker, an infant incubator scale for weighing the babies and individual wall suction and oxygen outlets. An oxygen analyzer is kept in the nursery at all times.

The premature and newborn unit is maintained as a self-contained isolation unit. A central room provides storage space for supplies as well as office space.

Used linen is collected in the nursery in identifiable laundry bags, is laundered separately and returned to the nursery with a minimum of handling. This separate handling of linen eliminates the need for sterilization.

A separate supply of easily identifiable premature nipples is maintained in the formula department. *—Sheila Nixon, Director of Nursing.*

out-patient department

THE out-patient department has been functioning actively since the hospital was established in 1909. It began in a room in the house that constituted the first hospital. It graduated into a few rooms in the basement of the old hospital. In the thirties it moved to six or seven rooms in a new addition which also housed admitting and casualty departments, pharmacy and social service. All these managed to carry on in spite of increasing congestion, which eventually became characteristic of every other department in the hospital. The new out-patient department was planned to function as a separate unit, but on the same floor, and not too distant from, x-ray, casualty, dental suite, records and admitting department. No longer are there the traffic snarls of the pre-appointment days in the old

Up-patient play area

Premature nursing unit

hospital. Often then the dentist looked for his patient under the benches near the toy box, and the pharmacist tried to find the mother whose child's medicine was ready, who couldn't hear him for the noise coming from the casualty room where a terrified three-year-old was having his stomach pumped and next door a harassed paediatrician was attempting to take a history from an equally harassed mother of a sick baby.

Just as in the hospital as a whole, so also the out-patient department combines the functions of service, education and research.

1. Service

Preventive and curative medical service is offered to all who cannot afford private care, the only requirements being evidence of need and age under sixteen years. This service is given to from 50 to 100 children every week day from 9:00 a.m. to 5:00 p.m., and in the case of emergency any day at any time. With the separation of other departments and facilities from the out-patient area, it became possible to plan active clinic services morning and afternoon, whereas most of the regular clinics had been held in the morning. In order to make the change-over as painless as possible, this re-organization of clinic times was carried out four months before the move to the new hospital, thereby adding to the problems in the old clinic but making the move to the new one much more satisfactory. General medical and surgical clinics are now held in the afternoon, with twelve specialty clinics at regular intervals in the morning, and a dental clinic every morning and afternoon, five days weekly. Overcrowding has been reduced and smooth functioning facilitated also by the development of an appointment system. This works well enough so that the waiting area (which is outside the out-patient department proper) is never filled to capacity. It is furnished so comfortably and decorated so attractively that patients sometimes come earlier than they should and stay after all their business is done. These various clinics are staffed by 60 doctors and dentists on the honorary attending staff of the hospital, many of them combining teaching with service as part of their out-patient responsibility.

Specialty clinics are set up and continued as the need arises but the aim is to provide as full a service as possible in the general clinic, referring major problems (or if a research program is developing, all patients suffering from a specific condition) to the specialty clinic. The specialty clinics currently active are: allergy, cardiology, dentistry, dermatology, ear, nose and throat, hard-of-hearing, endocrinology, ophthalmology, neurology, orthopaedic, plastic surgery and psychiatry. Besides these, the Society for Crippled Children and Adults of Manitoba holds weekly cerebral palsy and general diagnostic clinics by special arrangement with the hospital. The service given involves the active co-operation of auxiliary departments. Some of these (orthoptics, speech and hearing) are located in the out-patient area, whereas others such as physiotherapy, social service, cerebral palsy treatment centre and play department are located elsewhere. Space is provided for a branch laboratory and, with x-ray and pharmacy close at hand, the out-patient department, though separate, continues to function smoothly as an integral part of the new hospital.

2. Education

Experience in the out-patient department is a vital part of the educational program for student nurses, be they Children's Hospital students or affiliating nurses. It is effectively used also in the training of medical students, interns, residents and the medical staff itself. With general medical clinics in the afternoon, it is possible to assign senior medical students, as they come to the hospital in groups of six for four weeks, to spend four afternoons a week seeing their own patients (as they will very shortly be in practice). Close supervision is given by instructors who are full-time members of the University Paediatric Department or paediatricians or general practitioners in active practice in the city. All children who are brought to the O.P.D. for any purpose must first be seen in the general medical clinic so that an adequate survey of their total health picture may be made and the medical record be complete. If consultation is necessary, the student who saw the patient first frequently accompanies him to a specialty clinic either alone, or with the group as a whole when they attend a specialty teaching session in the morning. Such teaching clinics are held weekly or bi-weekly in ophthalmology, cardiology, hard-of-hearing, dermatology, orthopaedics and neurology. This arrangement is a valuable experience for the student, who acts as a general practitioner referring his patient. It is also of great interest to the specialists who can hear the patient's story directly and from the referring "physician".

In order to provide some contact with the community, it is arranged that each student visits, with the district public health nurse, one of the patients he has seen during his period in the medical clinic. Following this visit he reports to his group, the Professor of Paediatrics and other members of the staff, as to the nature of the child's disturbance and the possible relationship to it of the home and school situations. Each group of six, through this weekly presentation, is exposed to a variety of common medical problems, and has an opportunity to learn how to make use of community resources in helping solve them. Interns who

Patient sorting desk

Out-patient examining room showing service corridor

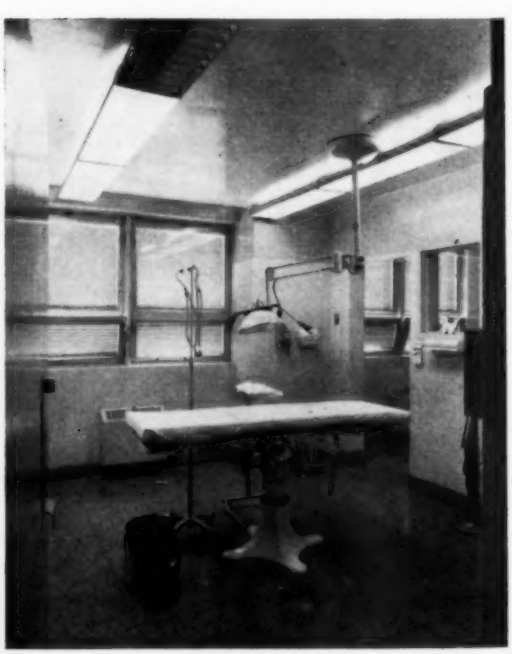
are spending time in paediatrics on rotation from St. Boniface or the Winnipeg General Hospital give service in the out-patient department on days when the students are not assigned. Each assistant resident spends one of his six two-month "services" in the out-patient department. Residents and interns are given close supervision by the director, his assistants and other staff members.

3. Research

Most of the special studies done in the out-patient department are in the nature of clinical reviews. Each year several of these, which prove to be of value to the whole medical staff and the profession at large, are planned and carried through. All children seen with hearing disability are reviewed at regular monthly meetings and the experience with them is presented annually to the full medical staff. The dermatology department has recently done a study on the problem of animal ringworm which became acute during 1956 and 1957. The dental department is developing an active research program toward the preservation of carious deciduous teeth. Periodically the ophthalmology and orthoptic departments review the results in the handling of children with strabismus; and similarly there have been presentations of the experience with convulsive disorder in the Neurology Clinic.

Physical Arrangement

Each of the six clinic rooms used for the general medical clinic has its own two dressing rooms. No patient need fear what has happened to his clothes while he is being seen, since no one uses this room until he leaves. This also reduces delay due to the complicated business of dressing and undressing children, especially in the winter time. These dressing rooms are along the inside corridor and hence its traffic does not interfere with the activity of the service corridor which extends the full length of the wing. It is divided from each of the six clinic rooms by a curtain which is surprisingly adequate in ensuring privacy. The lighting in the rooms is so effective that the periodic absence of light from the windows, when this curtain is drawn, is not a problem. Each clinic room is furnished with an examining table which contains the required instruments, a desk with compartments for various forms



Emergency treatment room

and a sliding board to be used for carrying out developmental examinations. Two or three chairs and a stool are all that is otherwise necessary since cupboards line the wall along the service corridor against the window. Each room has its own double x-ray viewing box so that the study of the patient's x-ray is a part of the physical examination and is used in the program of teaching-by-experience. All the clinic rooms have an intercommunication system to bring help from the attending nurse in the utility room. A similar inter-communication system between the outpatient desk, pharmacy, admitting desk and record room make for prompt and effective contact. There are special rooms designed for the ophthalmology, ear, nose and throat, and orthopaedic departments. The dermatology clinic has adjacent to it a dark room for the Woods lamp and this area is also used by several of the other special medical clinics.

We have been able to use this very effective unit for little over six months at this time and the inevitable complications that initially interfere with smooth functioning are gradually being eliminated. The service we are able to offer is given in a way that pleases the patients and their parents in attractive surroundings with minimal delay and adequate privacy. It is also a much more pleasant experience for the staff. Unquestionably the learning experience is an extremely valuable one for students, who will shortly be dealing with similar problems of their own. No doubt some will be designing their own offices to resemble the scene of much of their paediatric training.—*Wallace Grant, M.D., Director and President of the Medical Staff.*

medical records

THOSE of you who are aware of the internal functioning of a hospital will realize that in many respects the medical record department might well be considered the hub of the wheel, for without its efficient services many of the other departments within the institution would be handicapped.

The medical record contains the written evidence of all work done for the patient by the various departments within the hospital—the laboratory and pathology, the operating room, physiotherapy, social service and psychiatry. It even contains information valuable to the accounting department. All of these departments contribute to the medical record, as well as the records of the doctors and nurses. To assist in the collection of these records and in the smooth and efficient functioning of this "hub", the new Children's Hospital has been able to provide several important aids. Chief among these are a central dictating system, a pneumatic tube system, and files of a most efficient type.

It is a well-known fact that doctors usually work under a considerable degree of pressure and that they find it difficult to sit down and write progress notes and summaries. Since the value of a medical record depends largely upon the completeness of detail which it contains, we have installed a central dictating system to assist the doctor. There is a dictating station on each ward and one in the operating room, all of which record on a central receiver in the medical record department, from which they are transcribed. We encourage all private physicians to dictate a final note or discharge summary, one copy to be sent to his office and one for the hospital record, and if requested one may be sent to the referring doctor. We hope in this way to improve our own records, as well as to be of service to the doctor.

Another great aid to the smooth distribution and collection of reports is a system of pneumatic tubes connecting the record department with the wards, the operating room, the laboratory and x-ray departments. Any reports misdirected within the hospital, as well as reports from outside laboratories, et cetera, are redirected by the medical records staff to the correct ward or department. When an operative report has been dictated, the pneumatic tube is again used. The report form is sent to the record department for transcription and then back to the ward for the surgeon's signature and inclusion on the patient's chart.

For a hospital where the use of the medical record is so heavy, it is important that the charts themselves be readily available. We are fortunate indeed to have a method of shelf filing with pull tabs so that the records are more easily withdrawn and refiled. This is a tremendous improvement over the old drawer-style filing cabinet.

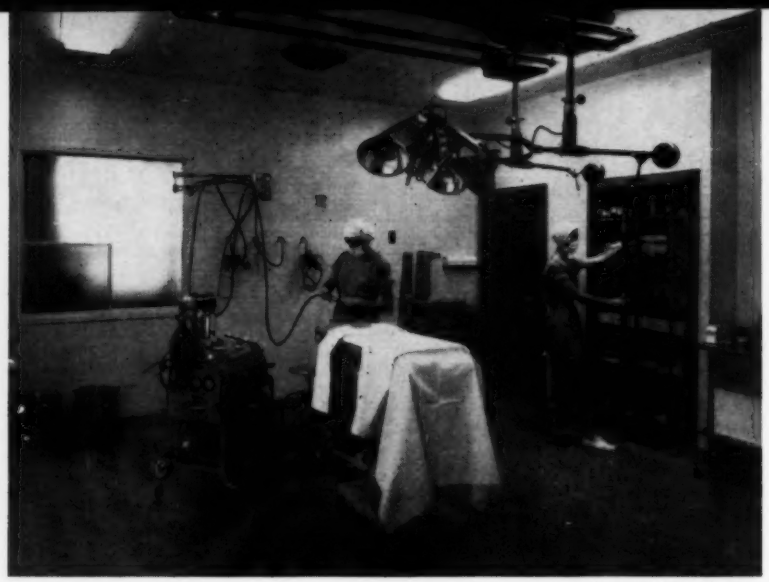
As with any progressive department, we keep seeing new ways of improving our services and our efficiency and we hope that through the years we may continue to maintain a modern and valuable medical record department.—*Ann E. Rackham, Librarian.*

surgical service

THE surgical service at the Children's Hospital includes neuro-surgery, plastic surgery, orthopaedic surgery, cardio and thoracic surgery, urology, ophthalmology, otolaryngology, dentistry and general surgery. Two wards, one for infants and the other for older children, are almost entirely devoted to surgical patients. Newborn infants requiring surgery are cared for in a special newborn isolation unit specially equipped and staffed by experienced nurses. All septic surgical cases are admitted to the isolation ward of the hospital. Children who have recovered from their surgical treatment and yet for some reason cannot be returned to their homes, are cared for on the convalescent ward where there are supervised playrooms.

Daily out-patient clinics are held in general surgery and dentistry. There are weekly clinics in otolar-

Medical records department



Operating theatre

yngology, orthopaedics, ophthalmology and urology. A plastic surgery out-patient clinic is held once a month. Speech therapy, hearing and eye clinics staffed by two trained technicians, are held throughout each week day.

The active surgical staff of the hospital consists of six general surgeons, two thoracic surgeons, five orthopaedic surgeons, four urologists, two neurosurgeons, one plastic surgeon and six otolaryngologists or ophthalmologists. On a rotation these men care for all staff surgical patients. The hospital, however, is open to all qualified doctors in the city and many surgeons on the courtesy staff have the privilege of admitting their private patients to the hospital for surgical treatment.

The chief-surgical-resident supervises the care of the patients on the entire surgical service. He is assisted by a senior assistant resident and by one or two junior interns.

The operating suite consists of instrument storage and utility rooms and five operating theatres. One of these is used almost exclusively by the orthopaedic service, two by general surgery, and the other two by otolaryngology and ophthalmology. The operating rooms are air-conditioned, have piped-in oxygen and suction and are of modern functional design. A stretcher bay in the main corridor keeps this passageway clear. All surgical bundles are sterilized in the central supply and are delivered to the operating room by a dumb-waiter. Facilities are available in the operating area for the rapid sterilization of special instruments required during an operative procedure.

The casualty unit, situated next to the ambulance entrance, is close to the x-ray department and to the admitting office. The unit consists of two emergency operating rooms with an instrument storage and utility room in between. Throughout the entire hospital where seriously ill patients are being cared for, there is piped-in oxygen and suction. One x-ray examining room is equipped for minor surgery to be performed in conjunction with x-ray examination, *i.e.*, aortograms, cardiac catheterization, rectrograde pyelography, et cetera.

Formal surgical ward rounds are held once weekly. These are attended by medical students, interns, residents and staff men. The rounds begin in the x-ray department, where the films on surgical patients are reviewed by the radiologist, and then a bed-to-bed discussion of the individual patients is carried out. Once a week a combined medical and surgical conference is held at which one surgical patient and one or two medical patients are presented. In addition to medical students, interns, residents and staff, these grand rounds are attended by general practitioners.

At regular intervals, the entire surgical staff of the hospital meets to review all surgical deaths and complications. Once a month the operating room committee, consisting of the anaesthetist-in-chief, the surgeon-in-chief, the operating room nursing supervisor and staff representatives from other surgical subdepartments, meet to discuss any problems in the administration of the operating suite.

A tissue committee meets every three months to review all operative cases in which no tissue is removed or in which normal tissue is removed.

In a further attempt to allay the fears of children being admitted to the hospital, a motion picture film designed for children, telling the story of what the hospital is like, is shown once a week. All patients scheduled for elective admission to hospital are invited along with their parents to attend this showing.

With an increasing number of medical diseases now being treated satisfactorily on an out-patient basis, the ratio of surgical admissions to medical admissions at the hospital is rapidly increasing. At the present time the number of surgical admissions approximates those to medicine. In anticipation that this trend will continue, plans are being formulated for the expansion of the surgical services. — *Colin C. Ferguson, M.D., Surgeon-in-Chief.*

induction and recovery

IN any hospital this is a crucial area from the point of view of patient treatment. In a children's hospital it represents, as well, an experience which may have calamitous after-effects on these little people's minds. The fear of the unknown, of pain and physical injury, of strange people, things and places, the fears transmitted by parents, brothers and other patients, make the operating room a turning point for good or ill in many children's lives. Without doubt the anaesthetist, who stands at the gate between consciousness and surgical sleep, has the greatest share in shaping these feelings which will become the child's future attitude not only to surgery but to hospitals in general.

As is now well understood, the home is the proper place to begin telling the child what the hospital is all about and giving him confidence in the people he will meet there. When the child comes in for admission a day or so before his operation, if he has been badly prepared by his parents, then he is extremely apprehensive about everything going on around him. The sympathetic treatment given him by the nurses helps a great deal but the operating room remains the dread unknown.

Very recently we have acquired

new drugs which are capable of calming the patient without depressing the vital functions of the heart and respiration. Research on the use of some of these drugs has been going on in this hospital for months. It may be possible to change the attitude to things which have been previously worrying the patient greatly, by using these drugs the night before surgery and an hour or so before going to the operating room. Anaesthetists and surgeons are greatly interested in these possibilities.

However, the atmosphere of the operating room is still of the greatest importance. At the Children's Hospital we are fortunate in having a staff who understand and are patient and gentle with children. It is a rule that no children are brought into the operating room while awake. It is too much to expect a child to lie calm and co-operative in a strange, brightly lit room full of masked figures and with rows of gleaming steel instruments in full view. Such attempts usually end with a terror-stricken youngster being physically restrained while an anaesthetic mask is rammed onto his face and foul smelling gases choke him into oblivion. The aftermath of such a nightmare may be terrible in a sensitive child.

At our hospital we have an induction room which contains absolutely nothing to alarm the child. It has something of the atmosphere of the playroom which can be found in every Canadian home. The walls are painted a restful green with pictures of Disneyland and nursery characters. The lighting is soft and indirect and we have a phonograph with children's records and stacks of comic books. Here there is nothing of the hustling efficiency of the operating theatres but rather the quietness and relaxation conducive to sleep. Often we have two or three children in this room at a time. Those little eyes watch us while we talk to and handle the fellow on the next stretcher and they decide about us in advance. If one is good, all are good, and vice versa. Panic and fear are catching diseases. We are extremely fortunate in having attendants who are sympathetic and intelligent with the children. The little patients feel that it is wonderful to have a friend who understands them, answers their questions, tells them stories and reads them comics while they wait.

Most children under four and a half and five years of age detest needles and resist efforts at venipuncture, often frantically. Children over five or six years of age will often co-operate to have a "mosquito bite" if it is done quickly, with confidence and cheerfulness. Therefore, for the little ones under four years of age we use rectal pentothal and bring them out of the induction room only when they are fast asleep. For the older patients intravenous pentothal is used and administration begun in the induction room.

Surgical recovery room

From the point of view of patient safety, a good recovery room is a necessity in a modern hospital. We have a seven-bed recovery room with a well trained staff, supervised by a full-time nurse under the direction of the department of anaesthesia. This ward can handle all the patients from the five operating rooms and does invaluable service to the hospital. All the equipment for resuscitation is kept here. Piped oxygen and suction are available as in the operating rooms.

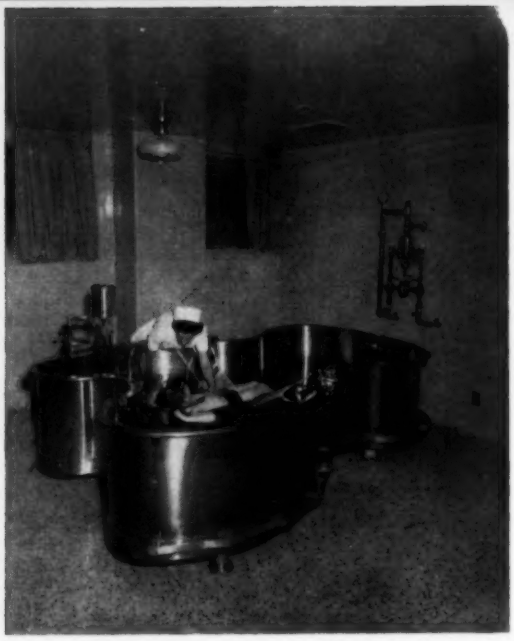
The importance of such a recovery room needs little stressing to most administrators. In a children's hospital a factor which is sometimes forgotten is the impact on the imagination of a child going to surgery of a bloody, insensible little figure being wheeled past in his crib by solemn-faced attendants. All this is avoided here. We tend to keep our patients quite a long time in the recovery room. The supervisor is not merely content with recovery of protective reflexes and reaction to stimulation but sends back children when they are conscious, calm and co-operative.

This description has dealt mostly with ideas, ideals and people—vitally important considerations. On the more material side we must mention that every modern facility is available to make operations safe for the patient and more convenient for staff. The suite is air-conditioned and humidity-controlled. Every precaution is taken to reduce fire and explosion hazards to an absolute minimum. Sterility is strictly maintained by rigidly observed rules with regard to dress and movement in the operating room area. All matters relating to the better and more efficient running of the operating room are dealt with by a special committee consisting of surgeons, anaesthetists and the operating room supervisor.

We are fortunate in having operating room workers who are conscious of the importance of this part of the hospital. On the other hand we are keenly aware of a sense of teamship with other hospital departments, all as important or more important than ours and all having a common ideal—better patient care. — *T. G. McCaughey, M.D., Anaesthetist-in-Chief.*

physiotherapy

THE physiotherapy department of the Children's Hospital takes up half the space of the west wing on the ground floor level. This level is most convenient as doors open onto the parking lot and patients in wheel chairs and on crutches can come and go without the inconvenience of stairs and elevators. The space is divided into



Hydrotherapy tank

two large treatment rooms, dressing rooms and office.

The first room is about 40 ft. by 16 ft. There are two cubicle spaces at each end, divided by a wall, and a large open space in the centre of the room.

In the centre are parallel bars for walking practice, a stationary bicycle, gym mats and large wall mirror. On the wall separating the cubicles at the west end are wall bars on which exercises are done. There is a mirror in every cubicle and one portable mirror that can be moved around the department or taken up to the ward. These mirrors are a great help when teaching walking and postural exercises. In this room we use our infra-red lamps, ultra-violet lamp and progressive treatment unit (Faradic, Galvanic and Sinusaidal currents). With children we find exercise the major form of treatment. Walking re-education, class work on the mats and bars and the increasing of muscle strength with our Delorme weight set, constitutes a large part of our work. Also exercises are done on the Guthrie Smith sling apparatus, which is a specially designed frame for the use of springs and slings.

The second room houses our swimming pool. This pool is graduated in depth from 3 ft. 6 in. to 2 ft. 6 in. and is 20 ft. by 8 ft. in size. It has steps leading into the pool and a hydraulic lift for patients unable to walk. The water is kept at 93° at all times. In this room too there is a Hubbard tank with whirlpool attachments. In this tank the patient can be treated individually in water while lying on a stretcher and the therapist can remain on the outside. There is also a small portable wax bath unit in this room. Adjoining this second room are dressing rooms and showers for the children and staff. The office is situated between these two rooms and is well equipped.—*Frances Colter.*

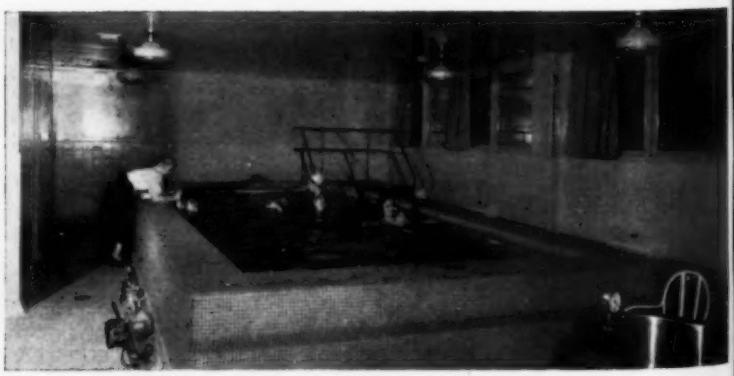
speech and hearing

THE speech and hearing clinic is located in the out-patient department. The patients attending are referred from the out-patient department if they are public or by the family doctor, paediatrician, otologist, et cetera, if they are private patients.

The greater part of the patient load is referred for diagnosis and treatment of speech, hearing disorders, and defects. Most of these children are pre-schoolers who have failed to develop adequate speech because of hearing, emotional, or intellectual problems.

The speech clinic is equipped with a variety of instruments necessary in differential diagnosis

Above and below: two large treatment rooms



of speech problems. Perhaps the most interesting feature is the "peep show", a device which has been designed in England and copied by the hospital work shop to make testing of hearing in young children more interesting for the child and more reliable for the doctor. The "peep show" is worked on the principle of conditioning. The child is conditioned to respond whenever the pure tone is given. The reward for the correct response is a "peep" at the circus of rotating animals. The most advantageous aspect of the "peep show" is that it eliminates verbal instructions. This has proved to be invaluable with the very young child as well as with the child whose hearing problem is severe enough to prevent the perception of speech at ordinary conversational level.

In addition to the instruments for hearing testing, there are numerous "sound toys". These are ordinary toys which have been calibrated and are used for a rough confirmation of the results obtained with the mechanical apparatus.

To help in the treatment program, the decor and furnishings are scaled down to our little friends' size. The miniature chairs and tables, the wall mirror, tape recorder, record player and the many boxes of toys and games all contribute to making speech therapy a pleasant experience for the child who is handicapped in either speech or hearing—*Angela Shirtliff, Speech Therapist.*

orthoptics

THE orthoptic clinic of the Children's Hospital was opened September 1st, 1937. At that time it was the first of its kind and is still one of the few in Canada; there is a technician working privately in Regina, and the same type of clinic at the Vancouver General Hospital.

The "squint clinic" as it is popularly called, treats not only the staff patients referred by the eye specialists in our own out-patient department, but also the patients referred privately by other eye specialists in Winnipeg, as well as elsewhere in Manitoba. All patients coming here have to be referred by an ophthalmologist and the treatment is carried out under his supervision; that is, reports are sent in regularly on the progress of his patient and he decides whether to continue treatment or not. It is often not a choice of treatment or surgery, as often both methods are resorted to to get a good result.

The main and only purpose of the orthoptic clinic is to teach the child "fusion". This may sound a bit confusing until you consider that we actually see with each eye separately and that the two images are "fused" or put together immediately by the brain so that we are only conscious of one image. To a child who has one of his eyes turning either in or out the images registering on the brain are not identical. This causes considerable confusion, so the brain will get rid of one eye by refusing to see with it. When this happens, the child has to be "patched", *i.e.* the good eye covered until the vision recovers sufficiently in the turning eye. This usually means that the formerly good eye will now turn also. This is one of the aims of "patching" to get the child to alternate, or look first with one eye and then the other. Other children alternate spontaneously so that patching is not necessary.

John, age three years, was admitted in January. At this time his right eye was turning out most of the time, especially when he was excited or daydreaming. He had normal vision in each eye. John started out on bi-weekly treatment but this proved too much for a small boy so he came in once a week instead. At first John had considerable difficulty in trying to get the pictures together. The pictures were in a machine which is patterned after the old-fashioned stereoscope still found in a few homes. It is a more elaborate instrument but the main object is still to get one picture. Slowly John developed more and more control of his eyes. It was a red letter day when he was first conscious of seeing double—"Look, Mummy, I can make you and Sharon two and then make you come back together." They were not two complete images but a blurred image with a ghost of another one beside it. This happened when John let his eye turn out—a blurred image—and a clear one with straight eyes. It took a year for John to finally have sufficient control over his own eyes that he could manage alone. John was the exception as to age. Usually children that young will tire of the constant repetition long before they are nearly cured.

Unfortunately age plays a very large factor in this type of treatment. With the exception of a certain type of eye condition, little can be done for adult patients as far as orthoptics are concerned. By adult I mean that even children age 16 are almost beyond its scope. Treatment such as patching can be started at one year of age if necessary. In fact when one eye and one eye only is turning, usually in, the earlier the patching is started the better. Once again it should be emphasized that all treatment given here is under the guidance of an experienced ophthalmologist, and this includes patching.

Technicians doing this type of work are specially trained either in England or in the United States. We, who have been American trained, took Board examinations set by the American Academy of Ophthalmology. The course offered over here is one year in duration. It has been extended to two years in England, where they have similar Board examinations.—*Marjorie Snell.*

play therapy

CHILDREN can be happy in a hospital. More and more in the field of medical science are coming to realize that the emotional needs of the child require as much attention as the physical, while he is a patient in the hospital.

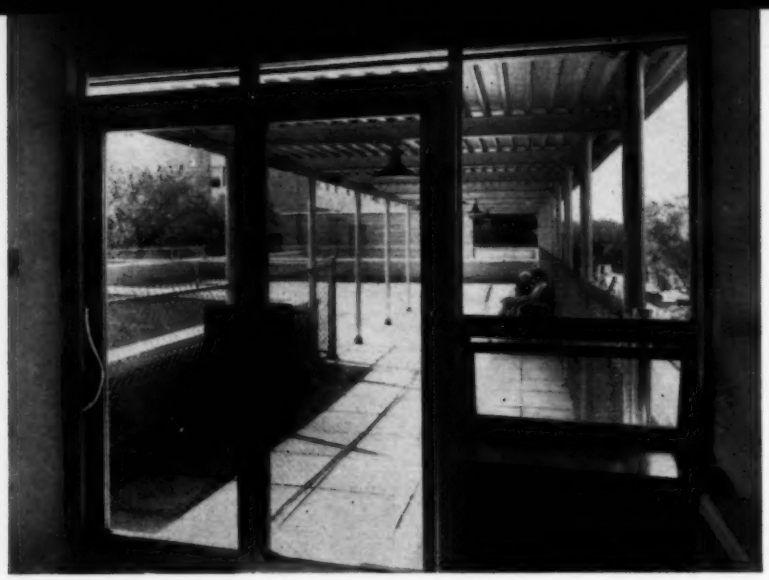
Play is considered an essential part of any child's life. To fulfil this need adequately it is necessary to develop in the child a sense of security, share with the child a personal appreciation of love and social relations, initiate and stimulate his constructive interests and arouse in him a sense of responsibility.

The department of play therapy was introduced to the Children's Hospital eight years ago by the Junior League of Winnipeg. The Junior League sponsored this for four years and the Elks for one year.

By observation it has been found that the play therapy department has helped to bring about relaxation and to attain a feeling of security for the child. It gives an outlet for his constructive ideas and interests, lessens homesickness, relieves nervous tension and develops good play attitudes toward his teammates.

When a child is in the hospital he is deprived of familiar environment, *i.e.*, his home life. Therefore it is our duty to try to supplement the child's home life as much as possible in the hospital. A sick child needs even more help than a healthy one to develop his interests and skills.

There are four playrooms in the



Play deck

new hospital, three located off the wards and the main and largest playroom in the Junior Red Cross Wing.

The main playroom is for the patients in the hospital, for out-patients and crippled children, and each year we treat approximately 8,337 children. The patients who come to this playroom range in age from sixteen months to sixteen years of age and they include both male and female.

The curriculum in this department is as follows: treatment for convalescents, those with behaviour problems, the emotionally disturbed, mentally retarded, children with brain injuries and cerebral palsy. Some of the children come to us from within the hospital and some through the out-patient department.

This is especially valuable in meeting the needs of the emotionally disturbed and those with behaviour problems, making it possible after a period of observation to arrive at a diagnosis in many cases.

These patients come to us for leisure time entertainment, socialization, mental assessment, therapy and observation for diagnostic purposes.

In supplying treatment we work with the hospital medical staff, psychiatrists, speech and physiotherapists, psychologists and community social workers.

The staff consists of a supervisor and two assistants. All student nurses are required to have this training and two new ones come to the department every three weeks. We use 40 to 60 volunteers a month, who are trained and supervised.

Provision has been made for the children who are left in bed. An invaluable service is rendered daily to these patients by a group of excellent volunteers. Two combination (toy wagon and library) carts are taken twice daily to the bed-ridden patients by volunteers, who, we might add, have been given the name of "toy ladies" by the children.

The volunteer is a special person in the hospital life of every child because she brings toys. This service has created an atmosphere of peace and contentment as opposed to loneliness and discontent.

On the ground floor of the new hospital at one end of the corridor are two large doors and on one of the doors can be seen a plaque which reads—"Furnished by the Elks of Winnipeg".

As we open these doors we can see a playroom which is most attractively decorated. The pale pastel colours on the walls, the attractive children's curtains on the numerous windows and the varied selection of toys, all make this room a fairyland.

There are all types of toys in this large, spacious room (45 ft. by 25 ft.) and each toy has a specific purpose.

Some of the equipment includes a piano, a television set, a combination radio and gramophone, a sand box on casters, a doll's house, doll carriages, big and little tables

Play therapy in one of the four playrooms

and chairs, large building blocks, tricycles, bicycles, cars, wagons, painting and black easels, hockey and baseball games and, of course, educational toys, most of which have been donated by very generous friends.

On one wall there is a long low shelf which contains toys for preschoolers. At the other side of the room are shelves filled with games and crafts for the adolescents.

Next to the playroom is the observation room and office of the therapists. On each wall there is a one-way mirror which allows for observation of the children at play —we can see them but they are unaware that they are being observed. Along with these mirrors is equipment which, when turned on, enables the observer to hear conversations.

It is hoped that we shall soon be able to demonstrate group therapy in the playroom. In the room adjacent to the observation room we can observe individual therapy being carried on.

Our ability to understand the child and meet his needs, makes his stay in the hospital happy and beneficial.

Those engaged in this work find it most interesting and rewarding and the part they play in the lives of these children is demonstrated by the eager anticipation with which they look forward to the arrival of the "toy ladies" and the staff.—*Marjorie Lynn McIntyre.*

dietary department

THE main kitchen is located on the ground floor covering most of the east wing. Two important features of it are daylight and spaciousness. The walls are of cream glazed tile which extends to the sound-proof ceiling.

Good ventilation has kept the kitchen free from cooking odours, steam and excess heat. A series of ventilators projecting from the ceiling circulate fresh air. In the cold weather the temperature can be thermostatically controlled and, during the summer, cross ventilation is provided by a generous window area along two walls. To remove cooking gases we have installed a special ventilator which covers the entire cooking area, replacing the common hood. Centrifugal force draws the steam up into the ventilating septum where the grease is caught in stainless steel troughs and baffles. Panels in front of the baffles open so the grease can be readily wiped off.

The receiving entrance adjoins the kitchen. Non-perishable supplies are stored directly below the kitchen and ordered in case lots, to be delivered to the daily storage room. Perishable supplies are immediately checked into one of three walk-in refrigerators in the receiving corridor. The meat refrigerator has a second door opening into the main kitchen cooking area. Cooled by a large opening from the dairy refrigerator, there is a four-door reach-in refrigerator used for leftovers. Our menu can include a variety of frozen foods because we have four reach-in freezers.

Decentralized tray service is used for the patients. The equipment has been arranged so that there is a direct work flow from the storage of raw food to the loading of food trucks. The kitchen is laid out in six areas—salad and vegetable preparation; main cooking area; bakery; pot washing; food wagon and tray trolley storage; dishwashing. Each area is a complete unit. For example, the bakery has its own sink, 30-quart capacity mixer, tilting steam kettle and shelving. The two arteries of traffic through the kitchen have been planned so they do not cut through these work areas, thus persons transporting supplies on carts and dollies do not disturb other employees' routine.

Dishwashing is centralized; the dishwashing area crosses one end of the kitchen. Stainless steel work surfaces extend from both sides of the dishwashing machine, providing room for stacking soiled dishes and allowing for air drying of clean dishes. Adjoining is a cart washroom equipped with a portable sink. Trays are reset and the tray trolleys remain in the kitchen until meal time. In this way the ward kitchens and corridors are not cluttered with trolleys, and dishes and cutlery cannot become "toys" for little children.

The equipment is of stainless steel with the exception of three work tables in the cooking area which have hard maple tops for cutting and chopping. The three ranges, deep fryer, and double-deck bake oven are heated by gas. To clean the range cooking surface, an electric tripod clean-up machine is used. It operates by rotating steel brushes.

Off the main kitchen is the diet kitchen, adjoining which is the dietitian's office. Most of the food for modified diets is prepared in the main kitchen but some special food and all nourishments are prepared in the diet kitchen. Each student nurse spends four weeks in the diet kitchen under the supervision of a dietitian.

The service elevator and a dumbwaiter are used to transport food to the wards and cafeteria. Both these elevators are conveniently located adjacent to the kitchen and from the second floor up they open into a short corridor leading to the ward kitchen and cafeteria. Other departments are not disturbed with dietary food wagons.

Ward Kitchens

The five ward kitchens are designed from one plan. Each is equipped with a two-door stainless steel refrigerator. The freezer space holds two one-gallon ice cream cartons and the unit is self-defrosting. A whole day's supply of baby formulae is kept in each ward refrigerator. For heating formulae and puréed food there are bottle and food warmers. These are set into portable trucks. They are similar in design. A partitioned rack inserted into a bottle warmer converts it into a food warmer. The inserts have been made to hold tins of strained meat and strained fruits and vegetables prepared in the diet kitchen. Milk dispensers are used throughout the hospital. The hot food wagons are plugged into outlets in the ward corridors where meals are served. Ambulatory patients eat at small tables in their ward playrooms.

Formula Room

This section consists of a clean-up room adjoined by a pass-through window to the preparation room. The former is equipped with a bottle washer, jet rinsers and generous storage space. The preparation room has a milk dispenser, autoclave, stainless steel preparation table, large refrigerator, a double compartment sink, hand sink and storage space. Along an inside wall are windows through which mothers may watch the techniques used in preparing their child's formula. Formulae are set in crates and sent to the ward kitchens via the dumb-waiter. One door of the dumb-waiter opens into the formulae room.

Top: Main kitchen. Centre: Formula preparation area. Above: Cafeteria

Cafeteria.

On the fourth floor the cafeteria extends across the east wing. With nearly continuous windows along two walls this room receives much welcome sunlight. To soften the glare, there are semi-opaque curtains interwoven with metallic threads. The copper painted chrome tables have tops of walnut-finished plastic. Matching copper chairs are upholstered in a red nylon interspersed with metallic threads. Bright yellow trays and china of a modern design complete the decor.

Added features in the cafeteria are—three sets of walnut, louvre design, folding walls which are used to divide off an area for special luncheon meetings. There is a 70-foot patio with a south exposure. The colourful chairs and tables on this sun deck have proved to be very popular during coffee breaks.

The cafeteria is open throughout the day to all hospital staff, student nurses, interns, and visitors. The staff eat in the cafeteria regardless of whether they bring their own lunch or buy their meal. All food is sold à la carte. Student nurses and interns are given identification cards which allow them to choose what they wish. The menu offers a choice of hot foods, sandwiches, desserts and frequently salads. During the morning and afternoon the cafeteria is well patronized for coffee, et cetera.

The food serving area is largely of stainless steel and is designed wherever possible for self-service. A water station is located in the centre of the cafeteria.

Trays are carried to the dishwashing room near the cafeteria exit. In this area is a garbage disposal unit and a fresh water scrapper attached to the dishwashing machine. A wetting agent is injected into the rinse which coats the china, cutlery and glassware, enabling them to air-dry without spotting.

To those of us working in the department, it is noticeable that efficient and pleasant surroundings are a major factor in creating congeniality and good morale among employees. We are particularly proud of our main kitchen and believe it has been designed to keep pace with future expansion of The Children's Hospital. — *B. J. Ball, Dietitian.*

laboratories

THE Children's Hospital is, in a sense, a research institution, making it necessary to provide laboratory accommodation that not only meets the day-to-day requirements of routine clinical work, but also provides modern up-to-date facilities for carrying out scientific investigation. Basic planning of the space requirements was determined by discussions among the pathologist, administrator, and the architects, Messrs. Moody and Moore. Once the space was determined, a firm of laboratory consultants was called in to offer advice and prepare final plans. The department was designed on the basis of the five cardinal concepts of adequate laboratory planning: function, flexibility, efficiency, health, and maintenance.

Under "function" the planners considered the general purpose of the laboratory, scope of work, and the capacity in terms of personnel. With "flexibility", the degree of permanence, location, and provision for future expansion was consider-

ed. "Efficiency" took in the general headings of convenience and material flow and traffic direction within the laboratory unit. "Health" considerations were based on safety provisions, adequate sanitation, ventilation, and illumination. "Maintenance" usually refers to cleaning and decontamination of equipment, flooring, walls and bench top materials.

The laboratory occupies the third floor of the east wing, an area of about 7,000 square feet. This location has been found to be most satisfactory from the point of view of accessibility to the wards and the operating theatres. The blood bank is located here in the area immediately above the operating theatres. It is, therefore, only a few steps to collect blood samples or to have quick frozen sections of tissues done.

The traditional location of the morgue is in the basement but in this hospital it is part of the regular laboratory. The morgue is reached by means of a service elevator, which also has an outside exit away from the main hospital entrance.

This is the ideal situation for any hospital laboratory and is not generally matched elsewhere. In the past, morgue and autopsy areas have usually been located anywhere but in the vicinity of the laboratory, and too often in the darkest corner available. However, the fault and errors of most laboratories in the past have been mostly due to negligence in the planning stages. The fact that these errors were not made is a high tribute to those who planned The Children's Hospital. It is indeed heartening at this stage of advanced hospital design to see the changed attitude that is now prevailing in relation to laboratories and their important function within a hospital unit.

A few years ago, the usual laboratory accommodation was barely tolerable. The pathologist would be asked for space requirements, with a warning that there was a limited budget provision (and this is still heard, even in this modern age). A carpenter was called in—usually from the maintenance staff— and some sort of counters and cupboards were thrown together in a haphazard manner. The laboratory in The Children's Hospital is unquestionably the very antithesis of this type of thought and planning.

The most modern equipment available has been installed. No efforts were spared to plan the laboratory on a completely functional basis. All plans drawn for the laboratory were studied in exacting detail by the pathologist and his staff. Further revisions were made during construction—all in an attempt to provide the best possible arrangement of furniture and equipment, as well as maximum space utilization. It is impossible to say that there is any wasted space as every inch of bench is laid out and installed with a specific work requirement in mind.

The laboratory is basically planned on the standard centre corridor arrangement, with entrance to the laboratory section just off the elevator lobby. The biochemistry, haematology, and urinalysis areas are grouped on one side of the centre corridor, with no physical divisions between the areas. The "U"-shaped peninsular bench arrangement was used for all of these areas with simple fluted glass and wood "partitionettes" mounted on top of the service panels. This system of dividing space results in a sense of spaciousness and, at the same time, segregates the basic operations into individual work areas. It also provides for more efficient supervision on the part of the chief technician or laboratory supervisor. On the opposite side of the corridor are individual rooms, including the pathologist's office, rooms for bacteriology, histology and research, and a laboratory for interns, a room for protocols and a wash-up and cleaning area. All of these sections were given separate rooms because of the work requirements.

Services such as gas, water, air, and electricity, were provided on a generous scale throughout the entire laboratory. As a general rule, double gas outlets, along with a single air and a polarized electrical outlet, cold water gooseneck faucet and cup sinks were provided at 8 ft. intervals throughout the laboratory. Large sinks for general wash-up and disposal were provided within reach of these areas and adequately serviced with hot and cold water.

Throughout the laboratory, adequate provision was made for sit-down work by the use of 31 in. benching, in contrast to the normal 37 in. high or stand-up type. Another feature is stainless steel pipette rinsers flush within the laboratory furniture, together with permanent mechanical connections. This permits automatic operation, as well as increasing available bench surface. The general storage for the laboratory area is provided within the corridor, with floor wall cases located at appropriate intervals throughout the length of the corridor.

In order to reduce the possibility of contamination of cultures, the bacteriology laboratory is a complete and separate entity. It houses facilities for complete routine and clinical investigations together with areas set aside for the preparation of media. Suspended wall cases were provided at all available wall space for the storage of materials, media and glassware, et cetera.

The biochemistry section was divided roughly into three areas, *i.e.*, research, routine analysis and a separate area for precision balances, photometers, et cetera. The section has a fume hood of adequate size and bench tops are of a black composition. This material was utilized because of its superior chemical resistance in contrast to other bench top finishes. It was used throughout the laboratory except in the histology and the wash-up and clean-up areas.

The urinalysis section is a dis-

Pharmacy

Haematology laboratory

tinct sub-division of the general area with space for reception of samples and storage of night specimens, as well as for the routine clinical work. A feature of this area is the stainless steel canopy hood that extends 6 ft. in length over the work benches for the removal of ammonia fumes. This hood is particularly necessary where the urinalysis section is located in the general laboratory area.

The haematology area, also a separate and distinct subdivision, was designed generally on the same basis as those for biochemistry and urinalysis with adequate space for reception of samples and their storage. Under-counter incubators were provided at proper locations throughout the laboratories as well as under-counter refrigerators. This is an extremely desirable feature as it enables the technical staff to store routine daily solutions within easy reach and saves walking to a large central refrigerator every time certain materials are required.

The pathology suite consists of the pathologist's office and laboratory, protocol room, and histology area.

The office is decidedly on the small side, but it was a preference of the pathologist that as much space as possible be utilized for laboratory work areas. This office is simply furnished with a desk, book-case, and a small bench for microscopic examinations.

The histology area again has a "U"-shaped arrangement of furniture for complete material flow within the area. A definite program for processing the tissue was laid down, bearing in mind that tissue would be coming from the autopsy room where the gross dissection is carried out. The other functions of killing, fixing and embedding, et cetera, are carried on in the histology area proper on the basis of a flow of work pattern.

A special feature of this area is the use of white plastic laminate bench tops which is contrary to standard practice and convention. The basic thought behind this procedure is the fact that black tops or other dark colours may lead to a certain amount of carelessness on the part of histology technicians. With a white top, care and cleanliness are facilitated. Staining solutions must be removed immediately if accidentally dropped on the bench surface or otherwise permanent colour spots will result.

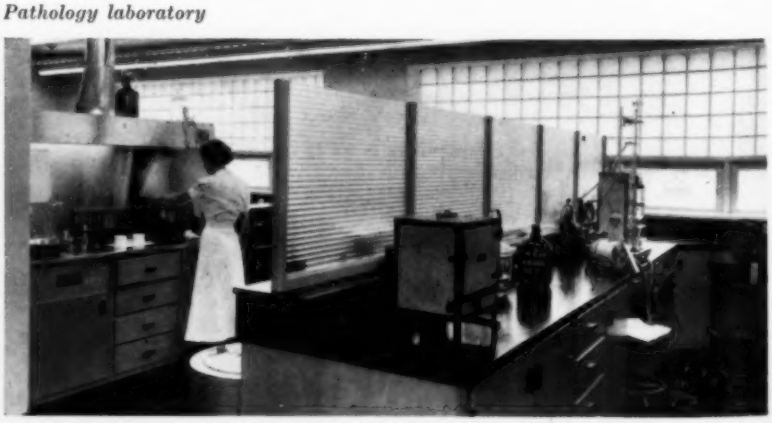
Across the corridor from the histology section is located the morgue, autopsy room and crock room, together with a large walk-in refrigerator. The morgue is furnished with a standard two-body side opening morgue refrigerator.

The area for general wash-up was designed with the idea that there would be at least two persons working in the unit. Stainless steel tops were utilized throughout, along with two sets of double sinks, one of which was fitted with a steam coil. Pipette rinsers were also furnished. Sterilizers for glass and media were housed here but recessed into the walls to eliminate some of the heat problems commonly found in this area. There is a pressure sterilizer, and a dry heat sterilizer, in this room. All available wall space is utilized for storage by use of either suspended wall cases or floor wall cases.

The whole department is well lit by multiple ranks of fluorescent lights. There is ample daylight provided by entire walls of glass brick, leaving only a foot and a half of clear glass at eye level. The flooring is of cement with asphalt tile covering.

Space has been provided for a Research Fellow in pathology and material is made available for teaching interns and student nurses. In the old hospital there was only room enough to carry on the routine clinical diagnostic work and no special research program. Now that this situation has been remedied, a department of research in the biochemical field is being set up under the direction of Drs. Harry Medovy, Sydney Israels and Jan Hoogstraten.—*This article has been assembled from data contributed by Beth Gourley, laboratory technician and J. Douglas Wilson of James H. Wilson Limited, Laboratory Consultants.*

Pathology laboratory



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O.H.A. Convention:

"Hospitals—Accepting the Challenge . . ."

October 28th to 30th are the days set aside this year for the annual convention of the Ontario Hospital Association, to be held in the Royal York Hotel, Toronto. Last year's theme, "The Hospital Challenge of the Future", will be followed up this year by discussions of health care services, which are stressed in the new theme: "Hospitals — Accepting the Challenge of the Future".

The topic set for the general session on Monday afternoon, October 28th, is "Your Hospital and the Ontario Hospital Services Commission". This will include talks by E. P. McGavin, C.A., D. W. Ogilvie, and the Rt. Rev. John G. Fullerton, D.P., on: budgets; the 1957 approach to prepaid hospital care; and, hospital facilities.

The general annual meeting is slated for Tuesday afternoon, and will be followed by a general session under the heading of "Trends in Hospital Design and Construction". New developments in this field will be discussed by H. G. Hughes, M.R.A.I.C.; the effect of changing function on hospital planning, by G. Harvey Agnew, M.D., LL.D.; and a panel will then discuss economies in hospital planning, the various aspects of which will be treated by D. F. W. Porter, M.D., R. Fraser Armstrong, B.Sc., LL.D., J. Gilbert Turner, M.D., and J. E. Owen, M.R.A.I.C.

Another general session, on Wednesday morning, is entitled "Predicting Nursing Needs". Marie E. Hudson, Reg. N., and Helen McCallum, Reg. N., will be the individual speakers, and a panel will discuss "Changing a Program of Nurse Education". Participants here will be Mary E. Macfarland, Reg. N., E. K. Jones, Reg. N., and Dorothy Colquhoun, Reg. N.

In the afternoon, a general session will hear talks by Frederick Evis, M.D., D.P.H., on hospital-medical legal problems, and by John B. Neilson, M.B.E., M.D., on the Canadian Commission on Accreditation.

Tuesday morning, for more detailed discussion, meetings of the following groups will be held: nursing administration section, trustees, accounting, dietetic, women's hospital auxiliaries, pharmacists, and laundry sections.

From 4 to 5 o'clock Tuesday, a representative group of High School students from the Metropolitan Toronto area will hear Eugenie M. Stuart, M.H.A., speak on hospital careers for young Canadians.

The annual banquet will be held Tuesday evening.

Imagination

The faculty for myth is innate in the human race. It seizes with avidity upon any incidents, surprising or mysterious, in the career of those who have at all distinguished themselves from their fellows, and invents a legend to which it then attaches a fanatical belief. It is the protest of romance against the commonplace of life. The incidents of the legend become the hero's surest passport to immortality. The ironic philosopher reflects with a smile that Sir Walter Raleigh is more safely inshrined in the memory of mankind because he set his cloak for the Virgin Queen to walk on than because he carried the English name to undiscovered countries.— *W. Somerset Maugham.*

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You Were Asking . . .

Several of this year's graduates in the course Hospital Organization and Management offered by the Canadian Hospital Association were asked to answer briefly the question: *Having completed the extension course in hospital organization and management, what do you consider was the main value of the course to you?* The responses received are as follows:

St. Joseph's Hospital,
Barrhead, Alberta.

WHEN as a neophyte in the art of management, I was appointed to administer a hospital, I found myself hesitant about such matters as how to approach the medical staff, how to appraise the nursing situation, how to co-ordinate the various departments into a smoothly functioning entity. Thanks to the course the guidance I needed was available. When today's mail brought my certificate, I felt that it is perhaps the most valuable diploma in my possession. Gradually, as the course evolved, there grew within me not only a broader knowledge of the many fields involved in hospital administration but I found that I developed a sense of courage and confidence with which to face and solve the various everyday problems that arise. Now, having completed the course, I can draw on a reserve of valuable experience gleaned not only from the discipline of completing assignments but especially from attendance at the intramural sessions. True, there is no magic formula for efficient administration, but with a background of knowledge of what one is about, one can step forward confidently to shape each day's destinies in that unique world dedicated to the works of mercy—the modern hospital.—*Sister Mary, Administrator.*

* * *

Miramichi Hospital,
Newcastle, New Brunswick.

I THINK the greatest benefit which I derived from the winter session was in the act of organizing. I was impressed with the need to organize and re-organize, the need to plan each step of the way and to consult with one's staff during the planning stage.

During the summer sessions I gained much from association with personnel from other hospitals. I learned that all hospitals have similar problems; that hospitals, like humans, are individuals requiring individual handling of their problems.

Chiefly I learned how much I needed to know, where to obtain the necessary information and how to use this information. Already I am finding my work going more smoothly as a result of what I have learned and expect this to continue as I have time and opportunity to put more of this training into practice. — *H. Jean Lynds, Superintendent.*

* * *

Port Colborne General Hospital,
Port Colborne, Ontario.

THE Canadian Hospital Association's course in Hospital Organization and Management gave me the opportunity to get an insight into the complexities and problems of the many "specialists" who make up the hospital team. It taught me the basic outline of their function in the hospital scene and was a sincere attempt to encourage me to see the other person's problems through that person's eyes.

The opportunity to listen to outstanding authorities on every phase of the hospital's function was invaluable. The theories they presented did not always coincide with my own, but they did make me realize that I should take a second look at mine.

The chance to participate in the curriculum of the course made me realize that my understanding of a hospital's function, which was coloured by the myopic outlook of a "financial specialist", had undergone a change in thinking and that I was taking a "generalist's" viewpoint toward the over-all objective of better patient care.—*D. Dickson Thornton, Administrator.*

* * *

Royal Ottawa Sanatorium,
Ottawa, Ontario.

THERE are many values as far as the course in Hospital Organization and Management is concerned. I feel they total up to "TEAMWORK":

T-hinking of the other person you work with.
E-ncouraging new ideas.
A-ssessment of Patient Care.
M-eeting face-to-face the many complex problems that arise every day.
W-isdom — in considering other people's feelings—the patient, his relatives and friends, the employees.
O-rganizing, planning and directing for the good of the hospital and the community it serves.
R-easoning—the why, where, when and how of a problem and its solution.
K-nowledge—the understanding of the duties and responsibilities of good administration.

The course taught me the need for and the importance of "TEAMWORK". — *R. F. Lawrence, Assistant Administrator.*

* * *

Royal Jubilee Hospital,
Victoria, British Columbia.

THE main value of the course, to me, is the broadening of scope and vision afforded every student. As we work along in our everyday jobs we may often fall into routine ways of performing tasks, and we may stray from the ideal concept of seeing the "whole" patient and the "whole" hospital.

Through the leadership provided by the course faculty we are forced to broaden our vision, to walk through each department and give it a searching look, and we are encouraged to read widely on hospital management, organization and departmental operation.

Completion of the winter assignments and participation in the summer sessions gives the students a feeling of belonging to the national hospital scene. We become aware of the importance of hospitals in the field of national health, and are introduced to ways and means of making a personal contribution to this field.—*John A. Syme, Purchasing Agent.*

* * *

Royal Canadian Navy Hospital,
Halifax, Nova Scotia.

THE Extension Course has meant many things to me. Knowledge gained, study habits acquired, the mentally invigorating experience of disciplining myself to the schedule, and the personal contacts made with classmates and faculty mem-

(concluded on page 122)

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SOCIAL SERVICE

in the hospital

A. L. Swanson, M.D.,
Executive Director,
University Hospital,
Saskatoon, Sask.

EVERYONE has social problems. Sickness or injury simply magnifies existing difficulties or adds to those already present. The successful athlete, the prominent business man, the society matron, the derelict from skid row, all have their social problems. Social considerations usually affect the patient's course in hospital to some degree and often to a very considerable extent—even to the point of nullifying the benefits of treatment. In recent years, psychiatrists, social workers and others have brought much information on these matters to the general public. Most of us are now aware of the effect inadequate social adjustment may have on our patients, but few of us, including those in the medical, nursing and hospital professions, have done much about it.

Probably if all the general hospital superintendents in Canada could be asked for their opinion on medical social service an alarmingly large number would state that they had not given the matter any thought. Another large group would present negative views such as: "You can only have a medical social service department in a large hospital. It's not practical in a small hospital." Another negative view is that social service is a form of charity work, that it is not necessary in prosperous times or that the relatively well-to-do clientele of a given hospital do not need it.

If we continued our survey of general hospital superintendents in Canada we would probably find a considerable number who would express themselves in favour of developing medical social service departments in hospitals. However, even in this group, a good many might be thinking of social service in a very restricted sense. One common belief is that the medical social service worker is a person whose main job it is to help in arranging for the discharge of long-stay patients, thus keeping beds available for acute cases. Another popular concept is to visualize the social service worker as a credit agency in assessing the ability of patients to pay their bills. Both of these are functions of medical social workers but in actuality are only two of the end results of good medical social service case work.

The relatively small number of general hospital superintendents in Canada who have been fortunate enough to have a medical social service department in their hospitals would undoubtedly express themselves in favour of a further development of this aspect of hospital care. They would likewise be able to list many advantages that might be expected as a result of a high standard of performance of medical social service case work.

Case work

Perhaps the best way to begin a consideration of the values of medical social service to the hospital would be to define medical social service or to state what it is that these social workers do. Social workers describe their activities with the term "case work". Case work may be defined in a variety of ways. Some of the definitions, like those in other specialties, become so technical as to shed very little light on the situation. As an administrator who has learned a little about medical social service in the past few years, I would like to offer my own description. "Case work" involves the total approach to, and appreciation of, the patient in his social setting. It consists of making an over-all, total evaluation of the patient and leads to the ability to construct an integrated plan based on the physical, emotional, and economic resources of the patient and his family and, quite often, of the community as well.

The complete evaluation of a patient in such a fashion can only be attempted by a qualified and skilled person. At the present time, the relative scarcity of trained medical social workers makes it difficult, if not impossible, for many hospitals of less than 150 beds to offer this service. However, I would submit that as appreciation for the value of social service work develops and the demand for social workers increases, there will be a corresponding increase in the numbers of young people who determine to make social work their career. In the meantime, what can be done in hospitals, particularly in smaller hospitals, to meet the social problems that exist for almost every patient irrespective of the seriousness of their illnesses, their economic position, or whatever?

Ideally we would hope that a social service department with one or more trained workers, depending on the size and needs of the hospital, could be formed. In the absence of a qualified worker, the hospital could designate some of the duties of a social worker to the mature, intelligent staff member who relates well with people. If it does not seem economically feasible to create a full time position for a social worker *per se*, other duties might be added, *e.g.*, those of an admitting officer. Such a person might well be called the "hospital receptionist". The receptionist's duties would be not only to admit the patient by completing the necessary documentation, but also to conduct the patient to the ward, introduce the patient to members of the nursing staff and, most important, to follow the patient during his hospital stay. Although the untrained person cannot perform highly skilled case work, the right type of person can learn some of the needs and resources of the patient. A hospital receptionist can help the patient to adjust to the hospital, can make the hospitalization period more pleasant, and can help in making preparations for successful discharge and rehabilitation. Probably the greatest service such a person could render is knowing of and making use of the many facilities offered by the various medical,

(concluded on page 66)

An address given at the Canadian Hospital Association Convention held in Saskatoon, Sask., May, 1957.

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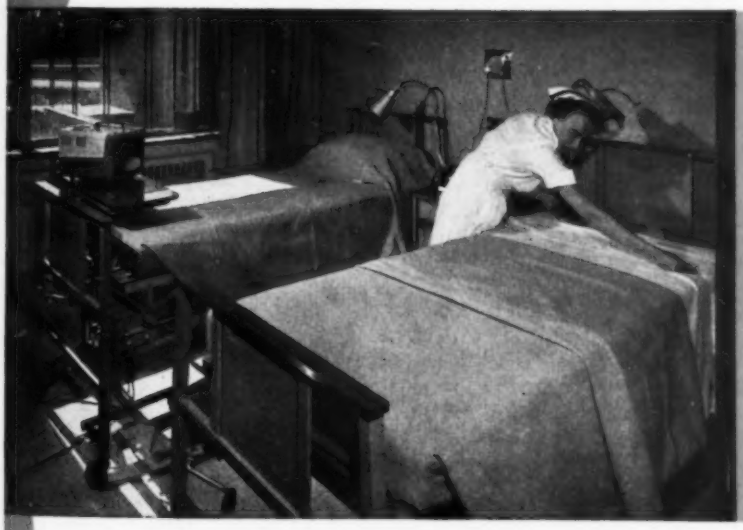

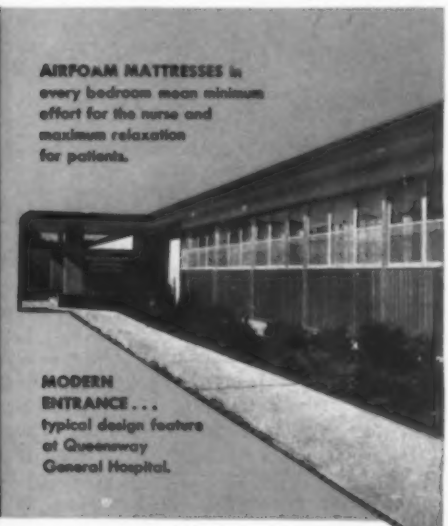

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Social Service

(concluded from page 64)

nursing, and welfare agencies in the community.

In many communities another potential source of help will be the married medical social worker who could give part-time service. Both the part-time, trained medical social worker and the full-time but untrained receptionist who may have other hospital duties are frowned upon by the medical social service profession. This is quite understandable, just as we realize that the medical profession would frown upon untrained or partially trained doctors, or would advise that doctors should practise their profession on a full-time basis rather than only part of the time. However, we have made and are making arrangements to share dietitians, radiologists, pathologists, technicians and others between two or more hospitals. We use nursing aides and assistants to augment nursing staffs. We see the positions of pharmacist and laboratory technician or of radiography and laboratory technician and many other combinations held by one person. We have to start somewhere and a part-time or semi-skilled service properly arranged is usually better than none at all. One word of caution: in attempting to make a start, beware of the "superficial do-gooder". The hospital receptionist or part-time social worker needs to be more than the effusive person who "has the time". The job requires a sincere, mature individual with a known knack of getting along well with other people.

Whether the hospital has a department staffed by trained workers, or whether the hospital is starting out with a part-time trained worker or a receptionist, there are certain results that the hospital superintendent should look for and should try to secure.

1. The social worker should perform a liaison function, helping to draw the whole treatment team together in an appraisal of the patient as a whole being.

2. Hospital patients should be more content as a result of relief from the many social and emotional problems that may beset them; *i.e.*, the worker may give reassurance when the patient is fearful and worried of death or disability, may relieve the patient's mind concerning financial worries, *e.g.*, his hospital bill, his income, et cetera. As the social worker comes to understand the patient, hidden worries concerning business or home life may be revealed and may be dispelled by the action of the worker or other members of the treatment team.

3. The social worker often is in a position to obtain accurate information on the economic position of the patient. This will have a bearing on charges by doctor and by hospital both as to amount and as to method of collection.

4. The discharge of patients should be smoother and swifter when complicating social problems have been recognized and solved.

5. The discharge of special problem cases will be much more rapid, provided the medical social worker has been called in at the beginning —as soon as the patient is admitted—rather than at the last minute when the patient is medically ready for discharge but some social problem is found in the way.

6. The social worker has a teaching role in every hospital. Teaching may be formal in nature to medical students, student nurses and other groups. Teaching is also informal at conferences with doctors, nurses and others. An important teaching rôle of the social worker will involve education in the hospital community, again on both formal and informal bases.

7. The social worker may be able to play an important rôle in aiding the hospital auxiliary and/or volunteers to the hospital.

8. She (or he) should be able to advise the hospital and members of the medical staff concerning the health needs in the community.

9. The social worker should be able to help patients make better use of health facilities, not only in the hospital but in the community generally, through knowledge of various facilities such as out-patient clinics, well-baby clinics and all manner of agencies dealing with health and welfare.

10. The hospital and doctors should be able to turn to the social worker for information concerning the various types of assistance available to patients, *e.g.*, welfare agencies and nursing services such as the V.O.N., medical treatment services, nursing homes and so on.

These are some of the results that can follow good medical social service case work in the hospital. Many of these results can be expected even in a small, part-time department. There can be no doubt that our complicated society will continue to force more and more social responsibility upon us as citizens. We must be ready to meet the social needs of our patients, not simply as a kindly gesture, but as a practical means of helping them to recover more effectively and more swiftly. The need for good medical social service exists in our hospitals now and the demand will be increasing as we move into the immediate future.

Ontario Blue Cross to Offer Supplementary Coverage

When the Ontario Government's hospital plan becomes effective on January 1, 1959, the Ontario Hospital Association will continue to operate a Blue Cross Plan for Hospital Care on a supplementary basis, according to a recent O.H.A. announcement. The association will thus make available coverage of hospital care over and above that anticipated in the basic plan of the proposed provincial scheme.

That many people in Ontario, as elsewhere, prefer semi-private to standard ward care is substantiated by the fact that well over 70 per cent of all those now enrolled in Blue Cross in that province hold semi-private contracts. C. V. Charters, president of the O.H.A. pointed out that there will be no conflict, duplication or overlapping between the provincial hospital scheme and Blue Cross. "Instead," he said, "the people of Ontario will have available better hospital protection than ever before."

Until January 1, 1959, Blue Cross will continue to operate as it has in the past, providing both basic and semi-private hospital care protection.— *O.H.A. Release.*

New Film Released

October 1st was the release date for the first general hospital film the American Hospital Association has made in several years. The title is "For the Love of Life". It provides a general picture of the hospital, showing the complexity of skills and services focussed on one person—the patient. It is 16 mm., in colour, and is cleared for television. It runs for 13½ minutes. Purchase price is $100; rental is $5 for three days, $1 for each additional day. The film is available at A.H.A. headquarters, 18 East Division Street, Chicago 10, Illinois.

Community-Auxiliary Relations

Mrs. J. E. Buchan,
Belleville, Ont.

WITH the advent of the community as the main support of the hospital, women's interest in this institution developed from one of charity to an attitude of community-mindedness. Collectively, as auxiliaries, they became the spearhead of this great 20th century development — citizen participation in the hospital field.

Time has seen the work of the auxiliaries develop until, at present, they are serving their hospitals in three general areas: fund raising, public relations, and volunteer service. As the hospital picture changes, each one of these fields should be studied for new developments. Let us scrutinize these three types of service to see exactly what the auxiliary offers the hospital.

Fund Raising

This service is common to all auxiliaries, though it undoubtedly plays a larger part in some than in others. The first question which comes to mind is: "For what purpose is this money raised?" It is put to use in three ways: to improve and extend patient care; to raise the general standard of the hospital; and to add the warmth and sympathetic interest of citizens to the scientific treatment offered by the hospital.

For the improvement of patient care, the auxiliaries' donations are largely those of equipment but we must also mention the hundreds of bursaries and scholarships offered annually to student and graduate nurses, which help to maintain a steady flow of recruits into this important profession and to encourage the ambitious to undertake post-graduate work. These contributions do definitely help to improve patient care.

The general standard of the hospital is raised by such donations as business machines; by the decorating and furnishing of hospital rooms; by supplying equipment for nurses' residences; and by making donations to hospital building campaigns.

From an address to the Saskatchewan Hospital Auxiliaries Association, June, 1957. The author is president of The Women's Hospital Auxiliaries Association of Ontario.

The warmth and sympathetic interest of citizens makes itself felt in the innumerable gestures of thoughtfulness, from flowers to brighten the wards, to providing and maintaining a summer convalescent home for elderly, low-income-bracket patients from the outpatient clinic.

Public Relations

An important objective of the auxiliary is to assist and actively support the hospital by creating favourable public relations in the community, at all times promoting the welfare of the hospital patient.

It is true that in the activities necessary to the carrying out of all its objectives, the auxiliary is involuntarily involved in public relations. Its money-raising projects, for instance, keep the hospital before the community. Also, the part the individual member plays cannot be over-emphasized. Because she *is* a member of the auixiliary, nonmembers will look to her for information. She is in an excellent position, too, in her daily contacts with her own friends, to meet criticism and explain misunderstandings.

More and more, auxiliaries are becoming aware of the importance of a planned public relations program and are taking steps to implement this, taking advantage of all the educational assistance which is offered in promoting this comparatively new venture.

Volunteer Service

In its early form volunteer service consisted largely of visiting, sewing and bandage-making. While still including these essential services, it has developed well beyond these boundaries and is now considered a service which demands of its workers not only dedication but education. The hospital and the auxiliary must be prepared to collaborate in setting up a sound course of training which will include psychology, business management, and hospital ethics.

The increasing desire to offer one's services within the hospital has reached such proportions in our metropolitan centres that trained professional guidance is a desirable objective and is indicated if the best advantage is to be taken of volunteer services.

Relationships

Having surveyed the three phases of work undertaken by auxiliaries, we may now attempt to estimate the relationship of the auxiliary and the hospital in each field.

In fund-raising, the auxiliary will find that its efforts are influenced by the community's impression of the hospital and money will be more easily raised where there are good public relations.

Clear-cut lines of communication with the hospital are of vital importance; adequate communication is the key to understanding. There are two methods of achieving this: (1) assure the administrator and the superintendent of nurses that they are welcome to attend the monthly auxiliary meetings; (2) arrange several meetings a year between the administrator and an auxiliary committee, when auxiliary plans and policy may be discussed.

The hospital, for its part, can establish most satisfactory relations by inviting the auxiliary to appoint one of its members to the hospital board.

It is important that hospitals should realize that they have a responsibility in seeing that education is made available to auxiliary members. It is obvious to both that the standard of auxiliary effort can only reach the level of the training afforded it. The goodwill ambassadors to whom we referred earlier will be educated largely through the efforts and the cooperation of the hospital personnel.

Planned public relations programs are a new venture on the part of most auxiliaries and, in order to promote better understanding, the hospital might be well advised to include the chairman of the auxiliary's Public Relations Committee as a member of its own parallel committee. Thus there will be mutal awareness of objectives, and overlapping in efforts will be avoided.

(concluded on page 128)

in Saskatchewan and Manitoba

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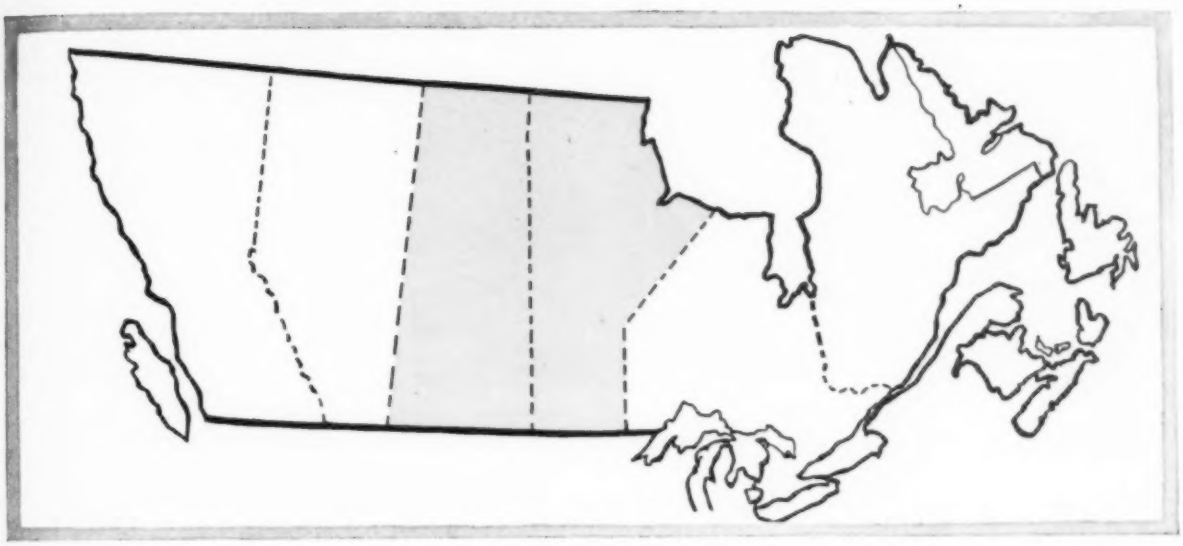

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*1957 (Canadian Hospital Directory)

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With the Auxiliaries

The auxiliary's gift shop at Winnipeg Children's Hospital

Raffles in B.C.

Raffles seem to be particularly successful as auxiliary activities. At Cranbrook, the ladies of the auxiliary to St. Eugene Hospital raffled a doll which brought $167 and at Tofino, the auxiliary of the Tofino General Hospital did well in raffling a round-trip airline ticket to Vancouver. At the Queen Victoria Hospital, Revelstoke, the auxiliary raffled off a hat at their spring fashion show and a fur neckpiece at their fall show, while the ladies of Trail-Tadanac Hospital did the same with a beautiful hand-made rug made by the husband of one of their members.

Ontario Convention

The auxiliary of Prince George and District Hospital, Prince George, also had an original idea when they sponsored stock car races at their May 24th celebration. They made a net profit of $1,200.

Successful Hospital Bazaar

The yearly bazaar of Bayview Memorial Hospital, Advocate, N.S., was held in July. There was a puppet show, bicycle parade and doll carriage parade for the children for which prizes were awarded for the best costumes. In the evening interesting pictures were shown in the public hall and rides in several speed boats were also enjoyed. This was followed by a dance in the public hall. Proceeds totalled over $600.

Hospital Plaque Unveiled

A plaque commemorating donation of the original building and land for Kincardine General Hospital, Ontario, by Mme Josephine Gualco in 1906 was unveiled at the hospital by Mrs. J. H. Scougall, who was a member of the first hospital aid.

Convention Plans

The Auxiliaries Division of the British Columbia Hospitals Association will hold their convention at the Hotel Vancouver on October 16, 17 and 18. A delegate from each auxiliary is expected to report on the current year's activities.

New Auxiliary

A new women's auxiliary to Sydenham District Hospital has been organized at Wallaceburg, Ontario, with the aid and encouragement of the Ladies' Assisting Society of the Public General Hospital, Chatham. The president of the sponsoring auxiliary installed the new officers.

Fair at Digby, N.S.

A fair was held in Digby in August which featured an exhibition of the works of local artists and craft workers. Another addition to the Digby General Hospital fair program was the golf driving range for which a unique setting was planned where activity continued throughout the afternoon and evening.

Auxiliary Activities

In the summer, the auxiliary of Grace Dart Hospital, Montreal, P.Q., held a military whist in St. George's Church which was very successful. Local merchants generously donated numerous door prizes. Nine lawn chairs have also been recently donated to the hospital by this auxiliary.

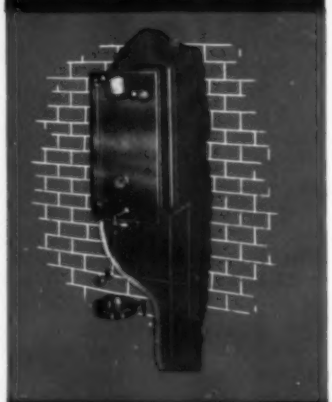
Canteen Proceeds Help Diabetics

The proceeds from the canteen operated by the auxiliary of the Jewish General Hospital, Montreal, P.Q., are used specifically for diabetic research and for the Day Centre for Diabetic Patients which is now being established in the hospital. The first of its kind in Eastern Canada, this centre will provide care and instruction for many patients with diabetes without requiring their admission to the hospital as in-patients. Patients will come in the morning and leave in the afternoon and receive instructions in the dietary and medical aspects of diabetic care so they can better look after themselves.

The canteen has 300 volunteers working four-hour shifts six days a week. It operates as a project of the auxiliary, but at the same time separate from it as a money-raising unit. There is a special sandwich brigade who staff the minute canteen kitchen and spend four hours a day making sandwiches; last year 26,000 were made. About 20 per cent of the canteen's daily sales come from the mobile canteen which is wheeled around the wards. Doll's baths are popular items for hospital-to-home presents. When the mother goes home with the new baby, the two-year-old has her own baby to bathe. Miniature bottles, brushes and hot water bags are also popular gifts for the junior-grade mothers.

Garden Party

The Lake of Two Mountains branch of the auxiliary to the Montreal General Hospital recently held a successful and largely attended garden party. In addition to refreshments, a sale of home cooking and fancy work, one of the most interesting features was a floral arrangement competition, which drew many entries.



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a hospital home care plan

J. O. Dale,
Administrator,
Vernon Jubilee Hospital,
Vernon, British Columbia

A PROJECT designed to provide the equivalent of hospital care at home is operating in the Vernon area of British Columbia. Service available under this plan makes it possible to shorten the stay for certain types of patients, thus releasing hospital beds for those requiring services obtainable only in hospital.

Known as the Hospital Home Care Plan this project was launched in 1951 as a pilot study financed by provincial and federal grants, to gather facts that could be applied on a wider scale. In choosing a hospital in which to institute the pilot study, it was desirable that:

(1) an area be chosen where there was an acute shortage of hospital beds;

(2) no organized community bedside nursing or housekeeping service be in operation;

(3) the area should be more or less self-contained with not more than one hospital serving its population;

(4) the wholehearted support of the medical staff and the board of trustees of the hospital be given.

The Vernon Jubilee Hospital appeared to meet these requirements, having only 108 beds, serving a population of 20,000 people, and its daily occupancy was well over 90 per cent. An Advisory Committee was appointed by the Union Board of Health, made up of the following members: one hospital board member, one member of the medical staff, one social worker, the hospital administrator and the superintendent of nursing, the medical health officer who is also the director of the plan, and the senior public health nurse, also the administrator of the plan.

In the initial stages the plan operated only in the winter months—the peak months of patient load in the hospital. The area to be served was the City of Vernon with a population of only 9,000, and 14 days of care was the limit of time set for any one patient.

The following October, *i.e.*, October 1952, it was decided to make the plan a year-round operation. Also the area was expanded to include adjacent rural localities to a radius of approximately five miles outside the limits of the City of Vernon; and patients were allowed to stay under the hospital home care program longer than 14 days at the discretion of the administrator. It has continued on that basis ever since. It should be stated here that admission to the plan can only be effected by the attending physician and of course it can only apply to a patient occupying a hospital bed.

Services

The nursing service is carried out by the public health nurses on a part-time basis in conjunction with their other duties in a general public health program. Nursing care as required by the attending physician includes: injections, dressing, irrigations; observation of progress, including temperatures, pulse, blood pressures, et cetera; collection of specimens for sedimentation rates, urinalysis and so on.

To date there has been an absence of time-consuming general nursing care such as routine bed baths, et cetera.

All housekeepers are on a part-time basis and are supplied with uniforms. Their duties can include: current cleaning, washing and ironing, preparation of certain meals, serving a bedside tray, and giving certain prepared medicines. They may also be expected to guide the children's spare time and discipline them if necessary. Work hours vary to suit the needs of any particular family.

Housekeepers are not to be considered domestic servants and the family is expected to help with the work at home.

The patient is charged a nominal fee of 50 cents per nursing visit and 50 cents per four hours of housekeeper stay. Inability to pay this fee does in no way exempt a person from using the plan.

Application of the Plan

First of all, to make the plan known to all, extensive publicity was given to it through the local newspapers and radio. Framed notices were hung in the waiting room and the entrance to the hospital. Pamphlets were printed explaining the plan, to be handed to patients who might be transferred to hospital home care. It was agreed between the hospital authorities and the medical staff that the head nurse on each floor may hand a pamphlet to a patient who, in her opinion, is a suitable patient for the plan. The head nurse then puts the name of the patient before the doctor for his consideration. If the doctor is satisfied that the patient can be transferred, the superintendent is so advised. She in turn telephones the senior public health nurse and the Hospital Home Care Service takes over, but before doing so the public health nurse picks up the doctor's orders together with any drugs and/or dressings needed. The hospital bills the Department of Health and Welfare* through the local health agency for any drugs and dressings taken. Should a patient need a bedpan, crutches or other such equipment, these can be borrowed from the local branch of the Red Cross Society who maintain a "loan cupboard" of such supplies. A chart for each patient is kept as long as a patient is on the plan and this is filed at the health unit office after discharge.

Before the patient leaves the hospital, plans are made with the patient or relatives regarding the care needed—nurse, housekeeper, or perhaps both. The nurse keeps in touch with the attending physician advising him of the patient's progress. Should the patient take a turn for the worse and cannot be looked after under the plan, he or she is re-admitted to hospital. So much for the mechanics of the plan.

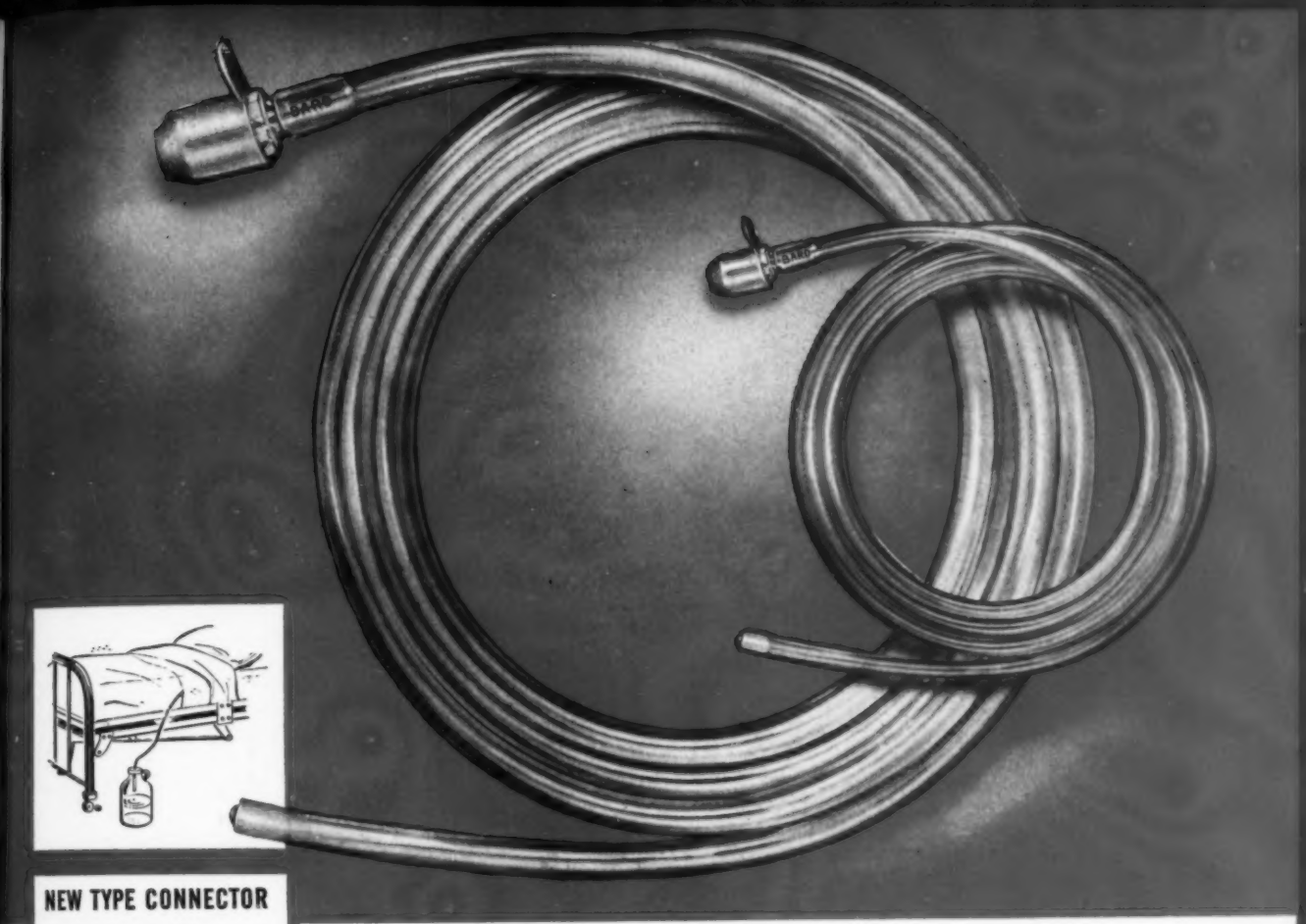
Record of Operation

The service completed its first year of operation on October 21st, 1953. A significant increase in the use of the service over the 12

(continued on page 124)

An address given at the Canadian Hospital Convention in Saskatoon, Saskatchewan, on May 30, 1957.

**British Columbia has a provincial hospital insurance service operated by the Department of Health and Welfare.*



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MEDICAL RECORDS

in a small hospital

Sister Marie St. Pierre,
s.g.m., R.R.L.,
LaVerendrye Hospital,
Fort Frances, Ont.

ORGANIZING a department simply means setting up a system which will correlate all procedures so that work will flow smoothly and the department can meet the demands placed upon it.

Basically, an efficient medical record system, be it in a small hospital or in a large one, is described in Clause IV of the *Minimum Standard for Hospitals:* "That accurate and complete medical records be written for all patients and filed in an accessible manner in the hospital . . ." In this very sentence are indicated the functions of the medical record department: "to secure, to preserve, and to use medical records."

You may object that standardization is now replaced by accreditation. This is quite true, but accreditation does not abolish the established standards. Accreditation amplifies the existing requirements, and its aim is "to carry on and further the great work undertaken by the standardization program: "the proper care of the sick and injured," and we know that medical records testify to the quality of care and treatment given to patients.

Let us therefore turn back to the *Manual of Hospital Standardization* and glance over the basic requirements upon which rest the organization of the medical record department, if it is to fulfil its function.

Equipment

"It is the responsibility of the administrator to provide an adequately equipped and staffed department, where the medical records are filed, indexed, and made readily available for use at all times for authorized purposes."[1]

"The medical record department should be conveniently located, adequate in size, and equipped with the necessary desks, typewriters, filing cabinets, supplies, et cetera."[2]

This clearly indicates that no organization is possible without an adequate office and the necessary equipment, and, I repeat, this is the responsibility of the administrator.

Personnel

In small hospitals, it is often indicated that one and the same person be assigned to several duties. There may be a combination of business office and medical records. It may be that the nurse superintendent or the operating room supervisor takes over the medical record department over and above her other duties. Whatever the case may be, medical record keeping has its own "technique" which should be adhered to.

"Hospitals would be well guided in the selection of medical record librarians, by employing those who possess training, that is, Registered Record Librarians. Too often the problems of a medical record department are unsolved or the difficulties increased by untrained and inexperienced personnel."[2]

I admit that actually there is an insufficient number of qualified persons in the field to satisfy the present needs. But this difficulty is on the way to being solved by schools for medical record librarians and the Canadian Hospital Association's extension course for the training of Medical Record Librarians, which is proving very successful.

Pending enrolment in an approved school or the C.H.A. extension course, the following books of reference would prove very valuable to the person placed in charge of the medical record department:

Manual for Medical Record Librarians, 4th edition, by Edna K. Huffman.
Medical Record Procedures in Small Hospitals, by Betty Wood McNabb.
Standard Nomenclature of Diseases and Operations, 4th edition.
Textbook and Guide to the Standard Nomenclature of Diseases and Operations.
The Bulletin of the Canadian Association of Medical Record Librarians.
The Journal of the American Association of Medical Record Librarians.

The first four books are available through the Physicians' Record Co., Chicago, Illinois.

Short courses and institutes are also held at intervals by the American Association of Medical Record Librarians, sponsored by the American Hospital Association. These short courses and institutes will impart fundamentals of medical record keeping, especially in the use of the *Standard Nomenclature of Diseases and Operations,* which requires specialized knowledge. Short courses will also give the beginner an insight into the medico-legal aspect of the medical record and professional ethics of the department as a guide in the release of information and the legitimate and illegitimate use of the medical record.

No matter how well qualified she may be, if the librarian assumes other responsibilities, she should be given sufficient clerical help for the detail work so that her own time be absorbed only by professional duties and supervision. A filing clerk or a clerk-typist, or both, may be required, depending on the size of the hospital, or rather, on the number of patients discharged.

Plan to Secure Records

"Every hospital should have some definite plan to obtain medical records. In small hospitals, where there are usually no interns, the hospital provides dictaphones which make it possible for the physician to keep up with his histories . . . The hospital should give the physician all assistance possible to relieve him of detailed work, but it cannot relieve him of providing a complete medical record . . ."[2]

Obtaining complete and accurate medical records in a large teaching hospital is not altogether a difficult task, because of the interns' participation. But in small hospitals, without interns, and even with dictating devices, experience proves that it is a problem—the problem. Doctors have constantly to be reminded of their obligation and the librarian should be given full support of her administrator in her endeavours to obtain histories on time.

"In addition to the above, the administrator has also the important duty of providing space in the medical record department for

doctors to write or review or sign their records."[3]

Not only doctors contribute to the medical record. The nursing division and the adjunct departments have to assume their responsibility in producing their respective reports and seeing that they are incorporated with the proper chart. Spot checks and instructions by the administrator at staff meetings, or in the classroom to student nurses or nursing assistants, would be very valuable to the librarian in obtaining complete medical records with a minimum of time and effort.

Supervision of Medical Records

"The attending physician reviews—or should review—the medical record at the time of discharge of the patient. He makes corrections or additions if necessary, and affixes his signature as an indication that the record is complete, accurate and approved."[2]

"The medical record librarian's responsibility is to check the material in the chart and ascertain that all component parts are included and properly assembled for permanent filing, but she is not expected to judge the "quality of the contents." This is the responsibility of the medical record committee, whose duty it is to review all medical records. Sufficient authority should be vested in this committee to "reject substandard records, pass judgment on the quality of the clinical entries and report delinquents to the staff, and in every good way promote and encourage the maintenance of good standards."[4]

In turn, the tissue committee, which in small hospitals could be incorporated with the record committee, has the duty of studying each surgical case and ascertaining whether surgery was justified and adequately performed.

It is also possible in small hospitals to have a medical audit committee in conjunction with the medical record and tissue committee. Through an individual medical auditor or a medical audit committee, "judgment is passed as to the agreement of provisional and financial diagnoses, pre- and post-operative diagnoses; whether complications and infections were inevitable; results as expected; and whether the treatment, medical or surgical, was justifiable, et cetera . . . " A medical audit is just as important as a financial audit and should be the concern of the governing board of a hospital whose responsibility it is, both morally and legally, to provide the quality of care and treatment given the patient.

Filing and Indexing

Numerical filing is the most common method used by hospitals now. It lends itself to either the serial or the unit system of numbering records.

Under the serial system, the patient is assigned a new number on each admission. When previous records are required for further treatment or other legitimate purpose, it becomes necessary to pull out as many charts as there were admissions for the same patient. This entails much work and is not considered efficient.

The unit system, as the word implies, collects in one folder, under the patient's *first admission*, all subsequent charts.

A combination of these systems is known as the serial-unit system. Under this method, all charts for the same patient are assembled under the *last admission*. This is practical in a small hospital without an out-patient department, especially when two departments function together, such as the business office and the medical record department, provided their locations warrant this. Thus only one set of patients' index cards is maintained and the same chart numbers are used by the two departments. This is the system we use in our hospital and we find it very satisfactory.

The keys required for the use of the medical records are the following: patients, disease, operation, and physicians' indexes.

The most acceptable form of patients' index is an individual card. It is prepared on admission of the patient. If the same index is used by the business office and the medical record department, a central place must be assigned for the in-patient index file. A unit card will record all admissions on the same card. It should contain the identification data, address and birth date of the patient, with dates of admission and discharge, attending physician, and number. A 3" x 5" card is most commonly used. We have found that the amount of information recorded on our index card permits us to identify the patient in subsequent admissions, without reference to the chart, and this saves time.

The disease and operation indexes are usually designed to record the essential data required in any type of research. All the information is coded, for simplicity. An adequate knowledge of *Standard Nomenclature of Diseases and Operations* is necessary for its use. A good knowledge of anatomy and physiology, as well as microbiology, are also essential requirements.

The physician's index may be a simple one or more elaborate, depending on its future use, but it must contain the result. Our physicians' index is designed to record the information contained on the medical record work sheet after completion of the audit. Again, this is coded, even the doctors' names, because of its confidential nature: only a person familiar with the code can interpret it. It is available to the medical audit committee, the administrator, and the individual physician, and it reveals the volume and quality of the work done by each physician.

Monthly Report

Preparing a monthly record is one of the duties of the medical record department. In other words, it is called "medical accounting". It is a statement made by the librarian, from the medical records and departmental reports, of the professional work done in the hospital for the benefit of the patient, during a given month. The yearly report is the sum total of all the services rendered during the year. It is a means whereby the administration is informed of the results of its medical staff. Without this monthly analysis, the staff and administrator cannot estimate the quantity and quality of work done, nor can the hospital estimate the care received by the patient.

Organization of the Department

"When considering the organization of a medical record department, it must be borne in mind that medical record departments throughout the country are as variable as the hospitals which they serve."[5] Therefore, once the basic principles are well laid down, the work plan becomes a matter of correlation and adaptation to the local surroundings.

In general, the organization chart of a medical record department in a small hospital should be mapped out to cover the daily, weekly and monthly duties.

The daily duties would include: admissions and discharges; assembling and quantitative analysis of records; coding and cross-

(concluded on page 84)

Medical Records

(concluded from page 78)

indexing (or indexing); physicians' index; filing; supervision.

In smaller hospitals, some of the weekly duties may be: posting of the coded data and requisition of supplies according to the hospital regulations. A day in the week may be set for correspondence.

In the monthly duties are included: the analysis of hospital service (monthly report or medical accounting), the preparation of records for review by the record, tissue and audit committee, et cetera.

Most of these duties have been discussed.

As regards admissions and discharges, it would be well to remember that "the medical record begins in the admitting office .... There the essential sociological data of an identifying nature and other information are obtained."[6] Insofar as the medical record is concerned, this information is recorded on the "Summary Sheet" which is the face sheet of the record, and upon which there should be sufficient space left for the physician to summarize the case and affix his signature. Once the summary sheet is numbered, whether by the admitting office or the medical record department—(if a unit system is used, this is done by the medical record office)—it (the summary sheet) goes up to the nursing division and initiates the patient's chart. The patient's index card is processed. A new card is made for a new patient. In case of re-admission, the card is pulled out from the master file, the date or admission is recorded thereon, and the card is filed in the in-patient file until discharge. Upon discharge it is completed and filed back in the master file.

Medical records may be brought down to a central office upon discharge of patients, provided they are safeguarded against loss, tampering, and unauthorized use.

A list of admissions and discharges is usually prepared by the central office, with a census count if so desired. This list is collected by the medical record librarian with the charts of all patients discharged the previous day. It is checked for accuracy, missing charts are called for, as well as previous charts which may have been required during hospitalization of patients.

The procedures then follow according to whether the record is complete or incomplete. Charts are assembled for permanent filing and checked for completion. If found complete, they are ready for the coding and cross-indexing procedure and the medical audit. Incomplete charts are returned to the attending physician or surgeon, with a deficiency check list, while deficiency slips are prepared and retained as follow-ups until all missing reports have been located and filed on the proper records.

Filing of late reports and complete charts should be done daily.

A guide system should be used pending completion of the records or their use in other departments. A guide is filed in place of the record and should indicate the location of the chart.

Supervision

"Physicians should be encouraged to complete records daily while the details concerning the patients are fresh in mind."[5]

This is the achievement that all should strive for—the governing body, the administrator, the medical staff, and the medical record department. This will pave the way to accreditation. A further study of the accreditation standards should be made if accreditation is contemplated, as it should be.

In conclusion, organizing a medical record department, be it in a small hospital or in a large one, requires an understanding of the basic principles and requirements, a study of the local conditions and a work plan covering all the duties attached to the carrying out of the threefold function of the medical record department: *securing, preserving and using medical records.*

References

1. *Manual for Medical Record Librarians,* by Edna K. Huffman, 4th edition, page 137.
2. *Manual of Hospital Standardization.*
3. *Manual for Medical Record Librarians,* page 138.
4. *Manual for Medical Record Librarians,* page 135.
5. *Canadian Hospital Association Extension Course for the Training of Medical Record Librarians,* Lesson 30.
6. *Manual for Medical Record Librarians,* page 31.

To say that a man is vain means merely that he is pleased with the effect he produces on other people. A conceited man is satisfied with the effect he produces on himself.—*Sir Max Beerbohm*

of the hospital team!

CIRCUIT CONTROL VALVE

The circuit control valve permits quick change of the "VERNI-TROL" from "Ether On" to "Ether Off." Inlet and outlet valves give a positive seal when "VERNI-TROL" is off. Opening oxygen flush valve shuts off ether flow.

LONG-SCALE FLOWMETERS

The 11-inch hand-calibrated flowmeters are easily read and their exceptional accuracy eliminates the need for "leveling devices." Two separate flowmeters each (high and low range) for oxygen, nitrous oxide and ether, provide an ample range for all techniques. Large visible floats are easily read against brilliant color background identifying the gases. A separate needle valve is provided for each flowmeter. *Models available with long-scale flowmeters only — less "VERNI-TROL" vaporizer.*

OTHER ADVANTAGES

In addition, the "Series 2000" Kinet-o-meter retains the "proved-in-use" features of the "Series 1000" Kinet-o-meter. All compatible accessories are available plus two new ones:

- B-D Mercury Column Type Blood Pressure Manometer Kit, complete with cuff, bulb, tubing, bladder and bracket
- A full-width handle for mounting on front or rear of cabinet

Catalog 4756 offers additional information, and our representative will be glad to call at your request to explain why the "Series 2000" Cabinet Kinet-o-meter is the ultimate in design and performance in an anesthesia machine.

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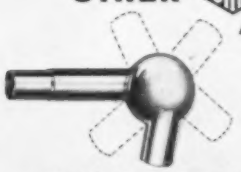

WOODHULL ADAPTER

The Woodhull Adapter (available in both 11 mm. and 15 mm. connections) allows coupling intratracheal catheter to gas machines at variable angles. The universal ball joint eliminates sharp angular turns, and reduces air turbulence. The added freedom of movement of the Woodhull Adapter makes it desirable in neurosurgery.

JACKSON TRACHEOTOMY TUBE

This silver tube with standard 11 mm. tapered outlet permits connection to standard anesthesia intratracheal fittings. This allows easier administration of anesthesia to patients who have undergone tracheotomy. Both tube and fittings can be used with a minimum of clearance. A lightweight elbow can be easily removed for suctioning. Outside diameter of cannula ranges in eight sizes from 4 mm. to 12 mm. *For more details, request Catalog No. 4727.*

ESOPHAGEAL STETHOSCOPE

The Ohio Chemical stethoscope receives more audible heart and respiration sounds as the transducer is placed in the esophagus. Connecting tubing contains a Luer-Lok union. Complete kit includes an acoustical transducer, connecting tubing and a self-retaining ear piece. *For more details, request Catalog No. 4757.*

INHALER "Y"

The "Y" is of durable, lightweight die-cast aluminum. With the 90° (15 mm.) mask elbow, the anesthesiologist or anesthetist quickly can switch from the mask to either the oral or nasal catheter. It can be had with or without an exhalation valve, and in both the 11 mm. and 15 mm. catheter connector slip-joint fittings. *For additional information, please request Form 4757.*

S-C-R-A-M® MASK

The SCRAM mask can be shaped to fit any facial contour. The malleable ring and plastic cushion can be formed to fit comfortably with a minimum of dead space. Molecular structure of rubber compound furnishes needed conductivity. Available in small, medium and large sizes. *For more details, request Catalog 4689.*

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C.M.A. Pilot Program

The Canadian Medical Association has decided to establish a pilot program of cancer courses for doctors in Nova Scotia. Speakers in specialized fields such as surgery, gynaecology, radiology and others will form a team to meet for one or two days in strategic parts of the province to bring latest information on cancer to the largest number of doctors, particularly general practitioners.

Since there were no requests from the C.M.A.'s 10 provincial divisions for special lectures on cancer last year, the organization decided its cancer fund might be better used on a pilot project which would blanket a single province. Experience in Nova Scotia will help decide if similar projects should be set up elsewhere.

Aid for G.P. Study

It was recently announced that the Rockefeller Foundation has granted the University of Toronto, in Ontario, $110,000 for studies of general medical practice in Canada. The money will be used to extend the survey of general practice which is being carried on by the school of hygiene of the university in collaboration with the College of General Practice in Canada.

Purpose of the project is to determine the scope of the general practitioner's work and to devise methods of coping with the problems which confront the physician in general practice in this era of rapid changes in the field of medicine.

Low-protein Malnutrition

Under study at the United Nations, New York, is "a world-wide child killer that takes its toll under more than fifty names". More serious than vitamin or mineral deficiency, it is protein malnutrition.

Its range of names includes infantile pellagra in South Africa, sugar baby in Jamaica, nutrition dystrophy in India and distrofia pluricarencial infantil in Latin America.

The U.N. agency specifically concerned with the problem, the Food and Agriculture Organization, estimates the death rate in some areas as 50 per cent of cases admitted to hospital.

The threat of this child killer is underlined by its simplicity. The most effective treatment is a diet of protein-rich skim milk, which in a matter of weeks transforms gravely ill children into normal, healthy ones.

F.A.O. officials point out that milk, taken for granted in North America, is often a rarity in backward countries. Once the growing infant stops receiving mother's milk, its diet needs protein from outside sources.

What happens, unfortunately, is that children in these areas go directly from mother's milk to an ordinary diet rich in carbohydrates but poor in protein.

To fight the problem, F.A.O. is attempting to increase milk production and distribution throughout the world.—*W.N.S.*

Film Award

The World Rehabilitation Film Award was recently won by "Teamwork in Action", a production of the Workmen's Compensation Board of Ontario which was in competition with 47 entries from 17 countries. The competition was held by the International Society for the Welfare of Cripples at the seventh world congress in London, England, in late July.

Here's a new blanket...

to end
shrinkage problems

woven by KENWOOD

from a patented process* made possible with

Orlon

This new addition to the excellent line of renowned KENWOOD blankets is the answer to shrinkage and "matting" problems resulting from adverse and abusive laundry conditions. The blend of 75% wool 25% "Orlon" acrylic fibre woven from the patented process combines the best qualities of both fibres.

- **Virtually no shrinkage... means longer life**
- **Retains original color and good appearance**
- **Provides warmth with less weight**

**The manufacture of this blanket is based on a U.S. and Canadian patent covering the use of acrylic fibre to reduce shrinkage in a predominantly wool blanket. The results of 50 test launderings of this particular blanket showed shrinkage of less than 2%.*

The new KENWOOD blankets come in attractive colors that harmonize with any color scheme.
Available through
KENWOOD MILLS LIMITED
Arnprior, Ontario.

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Provincial Notes

Saskatchewan

A provincial grant has been made towards a $44,000 addition to Moose Jaw's Providence Hospital, Moose Jaw. The addition will provide more adequate space for the laboratory and laundry.

A provincial grant has also been awarded to Leader Union Hospital, Leader, for the construction of a 15-bed nurses' residence, present accommodation of the staff now being considered inadequate.

Preliminary plans for a 16-bed extension to the Uranium City Hospital, Uranium City, are underway. Also in the line of construction, tenders have been called for an addition to the Neilburg General Hospital, Neilburg.

Working drawings are prepared for a 30-bed hospital at Kerrobert while at Lloydminster, tenders have been received for the construction of a two-storey and basement, wood frame and brick veneer building—a new nurses' residence.

The provincial government nursing home in Regina is now known as the provincial geriatric and rehabilitation centre. The centre in Regina is now being staffed and equipped to conduct a pilot project in rehabilitation. Other centres in Saskatoon, Melfort and Wolseley are also to be known as provincial geriatric centres.

The new Davidson Union Hospital, which opened in June now serves the rural municipalities of Arm River, part of the rural municipality of Rosedale, the town of Davidson and the villages of Girvin, Bladworth and Kenaston.

Ontario

Arrangements have been completed with the Sisters of St. Joseph of the Diocese of Sault Ste. Marie whereby they will conduct and operate the 100-bed Elliot Lake Hospital, Elliot Lake. Mining companies will provide $1,000,000 of the funds required for construction and it is hoped that an early start will be made on the project in this way. Estimated cost of the hospital is over $2,000,000. Twelve acres of park land have been provided as the site by the municipality.

Extension to the Ontario Hospital at Cobourg began in August as materials arrived for the $150,000 project. The extension will be an addition at three floor levels on the west side at the rear of the building. Improved storage and kitchen facilities are foremost among welcome additions.

A hospital devoted entirely to the diagnosis and treatment of nervous ailments was officially opened in Kingston in September. It is known as the Institute of Psychotherapy and is the first private hospital in this city. It consists of in-patient and out-patient departments and has a bed capacity for 14 patients.

Tenders were called in August for the new wing for St. Joseph's Hospital, Sarnia. Estimated cost is $1,200,000 and the wing will provide for 150 beds which will be divided into semi-private and four-bed wards. Enlarged laboratory and x-ray services will result as well as a bigger out-patient department and physiotherapy services. It is hoped that the wing will be completed before January 1959.

A grant from the Atkinson Charitable Foundation to St. Vincent de Paul Hospital, Brockville, will provide equipment for more efficient laboratory service and enable the expanding hospital to meet provincial requirements for autopsy facilities. The hospital is operated by the Sisters of Providence of Kingston.

Quebec

Plans for an extension to Hôtel-Dieu de St-Jerôme, St-Jerôme, call for a five-storey addition with two three-storey wings. Over-all dimensions will be 180 by 32 feet. Architect is David Deshaies, Nicolet, Que.

A new 60-bed hospital is being built in Arvida and will replace the present one built in 1927. The new Saguenay General Hospital will be built in the form of a T, four storeys high and divided into two wings. Located in one wing will be administrative offices, a pharmacy, kitchens, and cafeteria while the other wing will house all the general services of the hospital. It is hoped that the hospital will be finished in the autumn of 1958.

The new mental hospital at Annonciation, l'Hôpital des Laurentides, will provide accommodation for 800 mental patients. Completely fire-proof, the building will be of reinforced concrete structure with stone and brick exterior.

Prince Edward Island

The cornerstone of Hillsboro General Hospital, Charlottetown, was laid in March and the institution formally opened. This hospital is an active treatment centre for those suffering from nervous and mental disorders. The institution is supplied with the latest equipment in the diagnosis and treatment of mental disorders and is staffed by five psychiatrists, one psychologist, cancer and tuberculosis specialists, medical consultants and a dentist. The building is connected by a tunnel to the male and female division of Riverside Hospital although Hillsboro has its own operating room if surgery is required.

Newfoundland

A three-man Royal Commission was told recently that Newfoundland needs a 1,000-bed hospital to bring mental health services up to the federal government's minimum standards, and 400 beds to treat retarded children.

Deputy Health Minister Leonard A. Miller told the commission investigating Newfoundland's financial terms of union with Canada that 960 patients now are being treated in the province's only hospital for mental and nervous diseases, built to handle a top limit of 530. There are no facilities for the treatment of retarded children and no civilized country could condone the condition where such children were unable to obtain institutional treatment because no such facilities existed, Dr. Miller said. "Health authorities have recommended that 400 beds should be provided for that type of mental patient."

Importance of Hormones in Disease

Dr. Hans Selye, University of Montreal research scientist, recently produced evidence showing that disease-producing agents present in the human body will not cause disease unless there is an upset of hormone balance.

Dr. Selye produced bone overgrowth in animals by giving them an excess of sweet pea flour, and caused bone to be eaten away in other animals by giving them an excess of vitamin A. Then, by administering doses of hormones, he brought both bone conditions back to normal. A similar regulatory effect of the hormone cortisone has been shown to occur in inflammatory disease like rheumatoid arthritis. Dr. Selye's experiments are the first to show that the effect occurs also in non-inflammatory diseases. He used other hormones as well.

Dr. Selye criticized the overuse of cortisone. He said it is not just a drug but part of the mechanism of the human body. By administering cortisone, doctors are increasing certain phenomena which occur in the body. Besides ameliorating some diseases, cortisone actually can produce others which may be dormant in the body, he explained.—*The Globe and Mail.*

Open Visiting Hours

A radical change in hospital hours, introduced on an experimental basis by the Royal Jubilee Hospital in Victoria over a year ago, has worked so satisfactorily it has become a permanent program. Free visiting between the hours of 3 p.m. and 8 p.m. has received the approval of everyone concerned, administrative and nursing staffs, patients and visitors.

The results, after a year's time, have been most gratifying. There is less inclination, on the part of visitors, to stay too long, because they can drop in any time they are near the hospital. There is no concentration of visitors in the wards because they can come and go in their own time. Visitors are asked to leave whenever it is necessary to provide any hospital service for the patients, and this has been accepted by all concerned. Members of the nursing staff feel that open visiting has relieved them of many problems of discipline in the wards and has not seriously interfered with their normal duties. — *B.C. H.I.S. Bulletin.*

Notes on Federal Grants

Construction

The Manitoba School for Mentally Defective Persons, Portage la Prairie, has been awarded a federal hospital construction grant of over $57,300.

The grant will be used to help meet the costs of additions to and alterations in the present accommodation to increase this institution's bed capacity by 95. Costs of construction not covered by the federal grant will be met by the Province of Manitoba which operates the school as part of its psychiatric services.

The Manitoba School, founded in 1890, is one of the oldest institutions of its kind in western Canada. When the current building program is completed it will have a bed capacity of more than 900.

A grant of $5,070 will go towards the erection of a new Health Centre at Salmon Arm, B.C.

Built to serve the North Okanagon Health Unit, the building will provide accommodation for two public health nurses and one sanitary inspector. There will be a medical room, clerical office, clinic room and waiting room. In the basement there will be three workrooms for voluntary health agencies.

Construction cost will be met by local municipal and provincial contributions as well as by donations from the Tuberculosis Society, the B.C. Division of the Canadian Red Cross and the Canadian Cancer Society.

Municipal hospitals in Cardston and Drayton Valley, Alta., have been allotted hospital grants totalling $52,570.

The new hospital at Drayton Valley, which will serve about 4,500 people, will have 20 active treatment beds and an eight-bassinet nursery when construction is completed in the early summer of next year. The federal grant toward its building costs will be $18,500.

In Cardston, a new 38-bed hospital, with bassinets for 14 infants and modern medical, surgical and obstetrical services, is being built to replace a smaller hospital built in 1919. The old hospital will be abandoned as an active treatment centre when the new one is completed about next July. The federal grant toward the construction costs will be $34,250.

A grant of $11,500 has been made towards an addition to the medical nursing unit at Rossburn, Manitoba. The new construction, scheduled for completion in November, will raise the number of patient beds from ten to 19, and raise the number of beds for nurses by five.

This nursing unit will serve about 6,000 people. In addition to

(concluded on page 96)

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Surgical Gut
ATRAUMATIC® Needles

Delivers stronger, more flexible sterile sutures[1]

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Cuts surgical costs[1]

—fewer sutures damaged or opened unnecessarily...saves gloves and linens...stores in ½ the space...*now costs less than tubes!*

1. Alexander, Edythe L.: Mod. Hosp., May, 1957.

NEW! Spiral Wound Gut
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Sterile Pack Pre-Cut Silk and Cotton...aluminum foil envelopes... no glass to break...⅓ less storage space...costs less than tubes

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Silk, Cotton and Stainless Steel ...tape-measure box...one snip cuts multiple strands to desired length...saves waste, saves time...economy size silk and cotton costs less than spools

Federal Grants

(concluded from page 92)

the federal grant, the remaining construction costs will be met through provincial and municipal sources.

The Municipal Hospital in Red Deer, Alberta, is to receive $70,500 towards the addition of a third floor to the present structure, raising the total of beds by 60, and to the construction of a 51-bed nurses' residence.

The 1904 wing of the present structure will be demolished. Alterations to the main floor will provide for enlarged administration space, and certain other offices, along with the laundry and boiler room, will be moved out of the hospital to a new location. The present active treatment beds number 104.

The new third floor will not only raise the bed accommodation to 164 but will contain a solarium, isolation ward and paediatric department. Its exterior detail will match that of the 1939 wing. The nurses' residence will be of three storeys, and its concrete block and brick construction will be in keeping with the hospital itself.

Cost of the project will be assisted by federal and provincial grants and a debenture issue by the Red Deer Municipal Hospital Board.

A $112,000 grant has been made to the Hôtel-Dieu du Christ-Roi-D'Alma at St. Joseph d'Alma on Lake St. John, Quebec. This will go towards an addition to the present institution, a general hospital, which will more than double its capacity. The number of active treatment beds will be raised from 118 to 253 and 21 nurses' beds will be added to the present 18.

Operated by the Augustine religious order, the construction is being assisted by federal and provincial grants and the sale of debentures. It will be of concrete construction, with stone and brick walls in conformity with the earlier structure.

Research

A grant of $47,196 has been awarded to McGill University, Montreal, to assist diagnosis and research in virus infections in man.

The project calls for the establishment of a laboratory under Dr. Anne Marie Masson, who has been in charge of McGill's Division of Clinical Bacteriology for several years. It will be a part of the Department of Bacteriology and Immunology under the direction of Dr. Roger W. Reed, where its facilities will be available to all the teaching hospitals of the university.

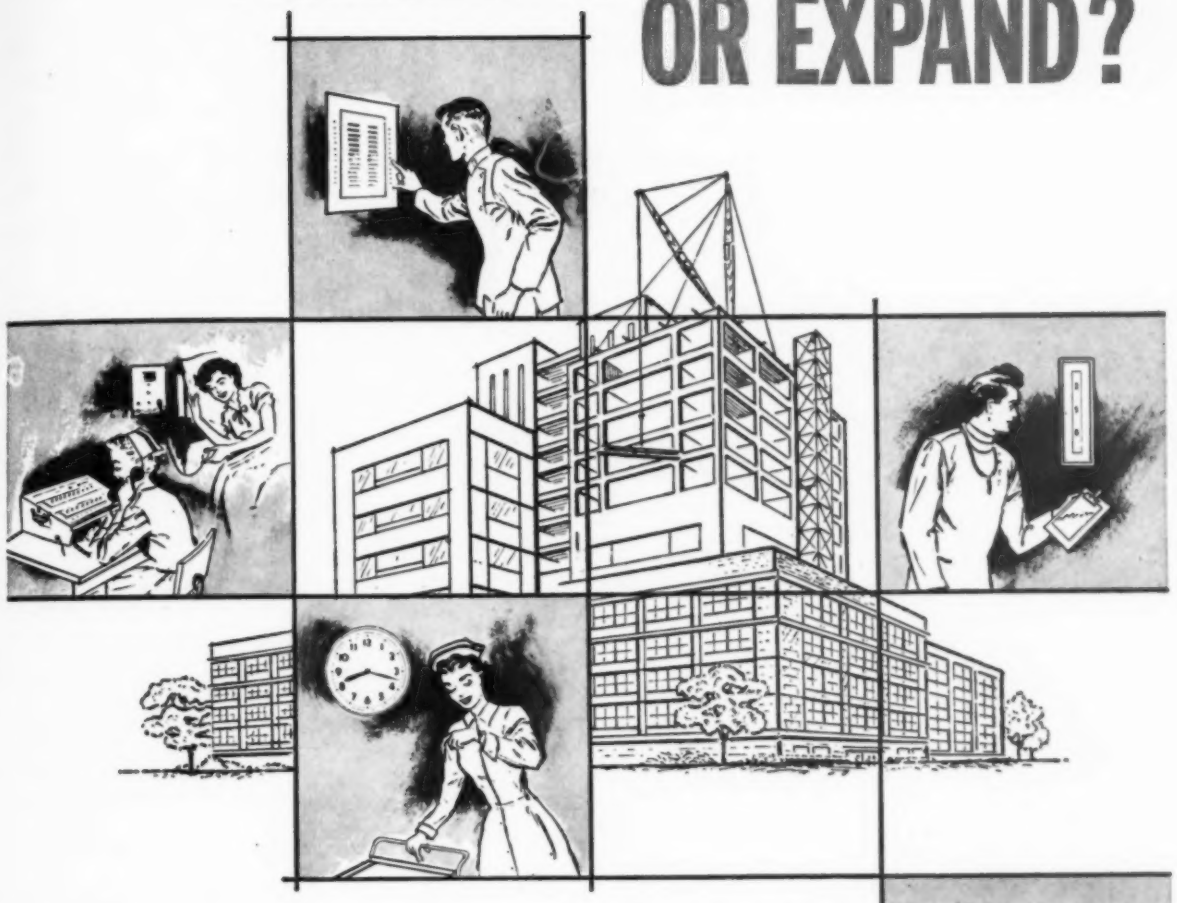
Space for the laboratory has already been made available by McGill, where the need for a laboratory has been recognized for some time. It will be located in the Pathological Institute. While it is anticipated that it will provide a useful service to all branches of medicine, it is expected to have special value in connection with diseases of the chest and of the central nervous system.

Lunacy

An amateur astronomer entertained a friend who was a rabid golfer. After dinner he insisted that the golfer take a look at the moon through his telescope while he delivered a lecture on its beauty. When he had finished, he asked, "Well, what do you think of it?"

"I guess it's all right," replied the golfer, "but it's got an awful lot of sand traps!"—*Davis Nursing Survey.*

PLANNING TO MODERNIZE OR EXPAND?



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Surgery and Therapy for Lepers in India

(Victoria Leprosy Hospital is in Dichpalli, Andhra Pradesh, India. The facts recounted here are taken from its annual report.)

Notable developments in surgical work are taking place at this hospital in South India. Crippled hands are being improved by transplanting the tendons of muscles which have been unaffected by the paralysis of leprosy to replace those that have become useless.

This work involves very delicate operating and very great care that no sepsis occurs, because a few unwanted germs in the operation site can make the most carefully planned operation useless. The orthopaedic surgical work involves a great deal outside the actual operating theatre, because hands have to be prepared sometimes for weeks or months beforehand. With disuse and neglect paralysed hands may become stiff and until that stiffness is removed the operation cannot be a success. This is where the physiotherapy department is of increasing importance; not only are the patients taught the proper care of their paralysed hands to prevent burning and other injuries which may lead to stiffness, but by regular exercises, massage and electrical treatments, fingers are made supple enough for an operation to be effective. After operation there is a period of several weeks in plaster, but then commences the really important work of re-educating the patient in how to use his "new" hand. If the physiotherapy treatment fails here, the hand may stiffen and all the value of the operation be lost.

Not only is the work of tremendous value in restoring function to deformed hands, but it may also be of great psychological value. The bent fingers may be a great stigma of leprosy and with such a stigma the patients may find it very difficult to face life. A deformed nose is a more important mark of the disease even than bent fingers, and so the new plastic operations for the repair of the nose are of great importance, not only for the cosmetic results but also for the psychological results in the increase in self-respect.

The hospital grounds contain a farm where patients raise rice, jawar, and bananas. Poultry farming has been started. A flock of sheep recently introduced provides much-needed manure for the land as well as wool. It is hoped that before long the patients will be making their own blankets.

The hospital office has been crowded with patients spinning and weaving. They make ropes, volley-ball and basket-ball nets and tapes for beds. Basketmaking is also carried on.

Although this is a Christian institution with Christian prayers and services to which anyone may come but to which no one is forced, the place exists for the care of all sufferers from leprosy irrespective of race, caste, or creed. There is no preference shown to a Christian patient or someone with an influential recommendation. Each one is judged on his merits and his particular need.

If I can line up the people who, back through the ages, have gone at life in ways I greatly admire, then I can feel all their strength supporting me, all their standards and values pointing the way in which I am to go.—*Bonaro W. Overstreet.*

NEW MOBILE "200" | *a General Electric x-ray unit in step with your progress*

NOW! A full-range x-ray unit for bedside radiography

Here's the power of a fixed x-ray installation plus complete mobility. With the new General Electric Mobile "200" you get all these features:

- *Full 200-ma, 100-kv output.*
- *Identical components, circuits and controls to those in major x-ray apparatus.*
- *Easy-rolling, rubber-tired movement* that puts full x-ray power at any point in the hospital.
- *Operation from wall outlets*—Any adequate 230-volt line will do. You can also work from 115 volts at reduced power.

With every feature essential to modern radiography, the Mobile "200" will prove a real asset in improving the quality of service and expediting case handling. Even within the x-ray department, it's an ideal standby unit when heavy loads swamp existing facilities.

Get full details from your G-E x-ray representative. Phone or write the nearest office of General Electric X-Ray Corp., Ltd.—Montreal, Toronto, Vancouver, Winnipeg.

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London Hospital Research Building

The new research building at the London Hospital (London, England) has been built out of the endowment funds of the hospital at a cost of £200,000 and provides accommodation for the research units working at the hospital. The accommodation, which is located in the main hospital, is being used for clinical laboratories. The research block, a three-storey building, accommodates on the ground floor the physicists' unit, the hospital instrument workshop and a department for research in industrial medicine. The hospital physicists' unit has been occupied since January, 1956. It includes four offices, one of them fully screened for occasional use as an electrically "quiet" room, two main laboratories, and one small isotope dosimetry laboratory, a dark room, local workshop and a components store. A room housing a 250 kV x-ray set for experimental use is shortly to be added. The department for research in industrial medicine is a Medical Research Council unit. The work of the department includes the study of acute and chronic poisoning by metals and chemical substance, industrial cancer and the effects of physical agents such as vibratory tools. The new building contains organic and inorganic chemistry laboratories, a laboratory for radio-active isotopes, and physics and histology laboratories. In the animal house a dosing chamber has been constructed in which animals can be treated with dust and fume in experiments planned to reproduce factory conditions.

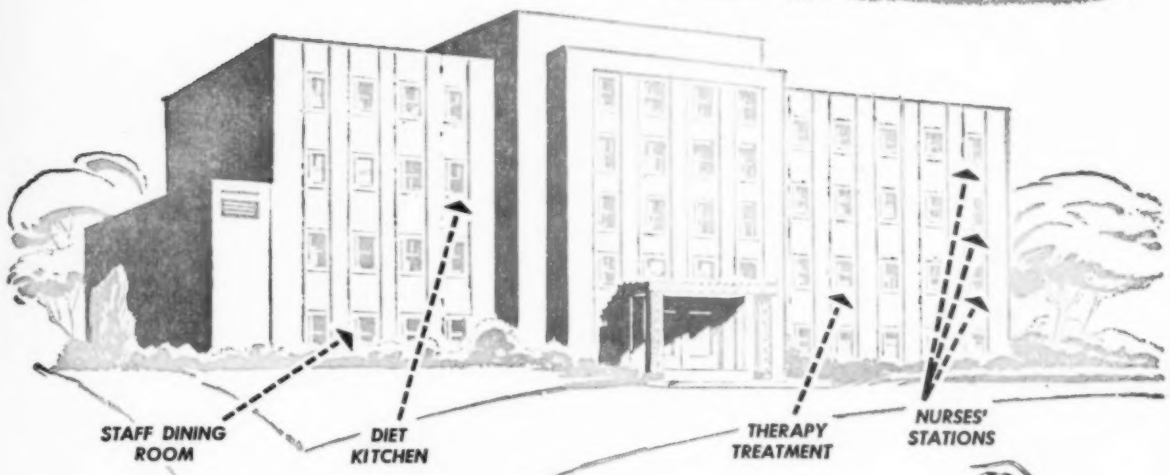
On the first floor there are venereal disease laboratories (including a M.R.C. reference laboratory), a social medicine research unit (M.R.C.) and dental research laboratories. At the social medicine research unit studies are taking place on infant mortality and several enquiries into the cause of "coronary thrombosis in middle-aged men", and it is planning to move into the field of mental disease and the relations of social to hereditary factors. Studies are also taking place in the working of various parts of the health and social services, for example, after-care and periodic school health examinations. A study has also been started on the problems of the London Hospital itself.

On the second floor a cancer research department is largely maintained by a grant from the British Empire Cancer Campaign. The department of experimental surgery is also on this floor. The department is divided into two parts, with a large laboratory being allotted to isotope work. The animal house is also on this floor.—*The Hospital.*

Social Hygiene

When Charles V retired in weariness from the greatest throne in the world to the solitude of the monastery at Yuste, he occupied his leisure for some weeks in trying to regulate two clocks. It proved very difficult. One day, it is recorded, he turned to his assistant and said: "To think that I attempted to force the reason and conscience of thousands of men into one mould, and I cannot make two clocks agree."—*Havelock Ellis in "The Task of Social Hygiene".*

SCOTSMAN ICE MACHINES
on every floor!



Save time . . . Save work . . . Save Money

Whatever your ice needs — there is a Scotsman Automatic Super Flaker or Super Cuber to meet every one. You can locate a Scotsman Ice Machine at stations on every hospital floor. Low priced, efficient Super Cubers will save time, work and money by providing solid, sparkling, sanitary Super Cubes right where they are needed. No need to "haul" ice from a remote central plant.

When flaked ice is needed for cold packs or therapy the Scotsman Super Flaker supplies dry, hard, free-flowing crushed ice. This superb Scotsman ice is made quietly without grinders, choppers or knives, using a mechanism which is the most dependable, yet simplest, ever designed. Again, simply locate a machine where ice is needed.

Warm weather brings heavy ice demands. Now is the time to write for complete information and facts about SCOTSMAN — America's only complete line of ice machines designed and priced for every hospital need.

For kitchen and staff dining rooms Scotsman Super Cubers are available in sizes which produce from 110 to 500 pounds of Super Cubes daily. Exclusive Scotsman "Cycle-Matic" control guarantees perfect cubes every harvest — cubes that are actually purer than the water from which they are made! All Scotsman Ice Machines operate on standard electrical connections.

Super Cubers
produce up to 500 lbs. of cubes daily.

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produce up to 1050 lbs. of flaked ice daily.

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Just printed are two new illustrated catalogs, on Super Cubers and Super Flakers. Each tells the story of how these popular machines operate, how they are applied, and what they can do for you. Write for your copies today!

Coming Conventions

Oct. 15-18—British Columbia Hospitals' Association, Hotel Vancouver, Vancouver, B.C.

Oct. 15-18—Saskatchewan Hospital Association, annual meeting, and A.H.A. Institute on Operating Problems of Small Hospitals, Museum of Natural History, Regina, Saskatchewan.

Oct. 22-24—Associated Hospitals of Alberta, convention, Provincial Auditorium, Edmonton, Alta.

Oct. 27-28—Catholic Hospital Conference of Manitoba, Misericordia General Hospital, Winnipeg, Man.

Oct. 28-30—Ontario Hospital Association, Royal York Hotel, Toronto, Ont.

Oct. 29-31—Manitoba Hospital and Nursing Conference, Royal Alexandra Hotel, Winnipeg, Man.

Oct. 30-31—Manitoba Women's Hospital Auxiliaries Association, Royal Alexandra Hotel, Winnipeg, Man.

Oct. 31-Nov. 1—Ontario Conference of the Catholic Hospital Association, St. Michael's Hospital, Toronto, Ont.

Nov. 11-15—A.H.A. Institute on Housekeeping, King Edward Hotel, Toronto, Ont.

Mar. 3-6—Joint Nurses-Surgeons meeting sponsored by the American College of Surgeons, Commodore Hotel, New York City.

June 12-14—Canadian Association of Physical Medicine and Rehabilitation, Annual Meeting, Quebec City, P. Q.

June 21-22—Conference of Catholic Schools of Nursing, annual meeting, Atlantic City, N.J.

June 21-26—Catholic Hospital Association of the United States and Canada, annual convention, Atlantic City, N.J.

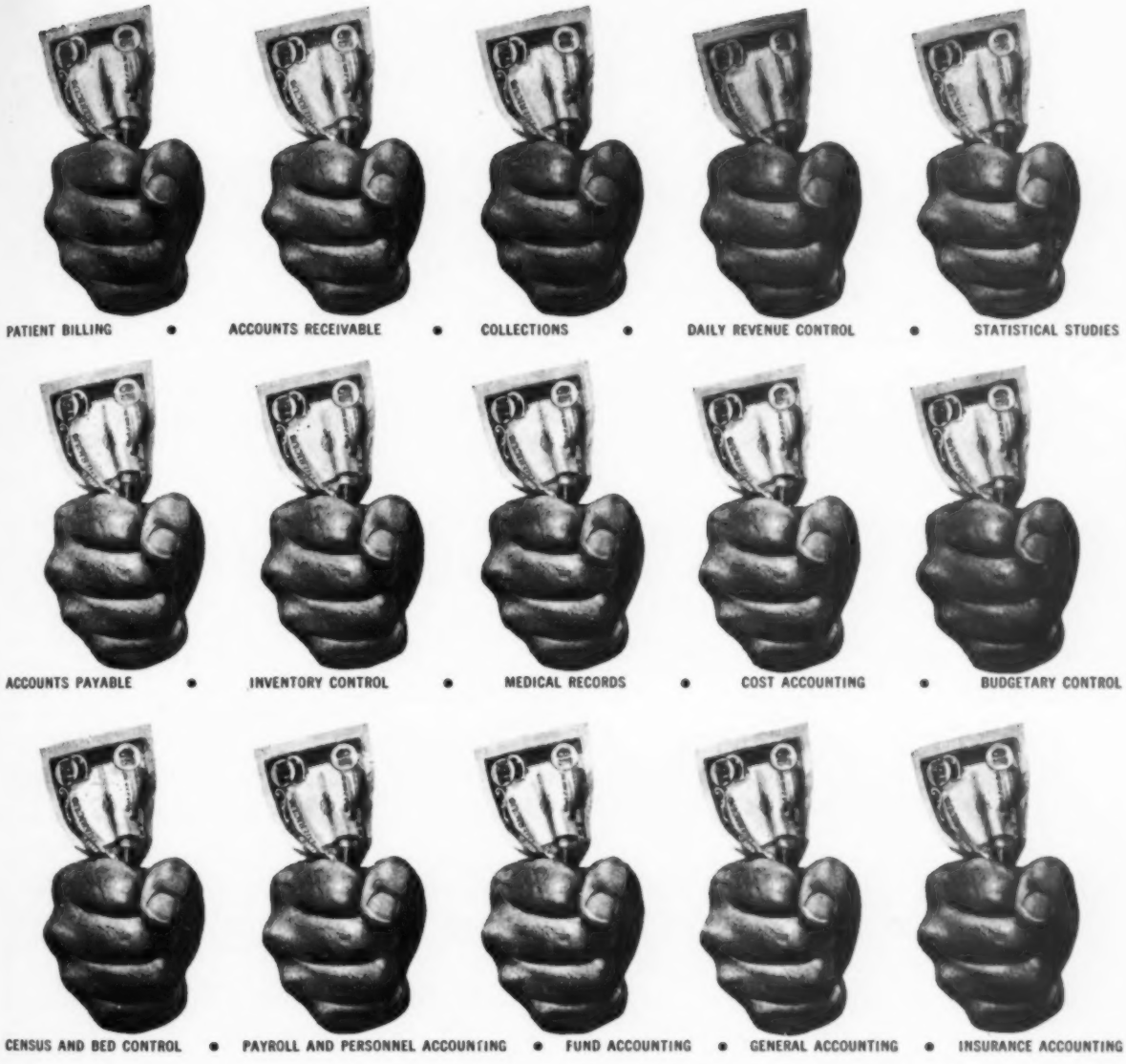
June 25-27—Comité des Hôpitaux du Québec, annual convention and Commercial and Scientific Exhibition, Montreal Show Mart, Montreal, P.Q.

Housekeeping Institute

Various topics are to be discussed at the forthcoming Institute on Hospital Housekeeping to be conducted by the American Hospital Association at the King Edward Hotel, Toronto, Ontario, November 11 through 15. These include discussions of: the hospital and the community; the housekeeping department and the hospital; organization and management of the department; the art and science of effective communication; principles of supervision; factors influencing productivity; control of infection; colour, texture and design in hospital decoration and furnishing; tools of the trade; care and cleaning of walls, windows and ceilings; types of flooring; cleaning and waxing procedures; conductive flooring; and development of a procedure manual.

An Ideal

To live and let live, without clamour for distinction or recognition; to wait on divine Love; to write truth first on the tablet of one's own heart—this is the sanity and perfection of living, and my human ideal.—*Mary Baker Eddy.*



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Notes About People
(concluded from page 28)

Regina, Sask. Her successor is Sister Delia Clermont who assumed the administratorship of La Verendrye Hospital September 4th.

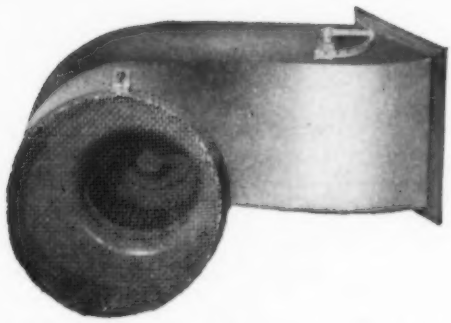
- Former supervisor of the operating room at the Prince Rupert General Hospital, Prince Rupert, B.C., Mary Densky, R.N., has accepted the post of head nurse at Stratford General Hospital, Stratford, Ont.

- George S. Dixon, has left South Waterloo Memorial Hospital, Galt, Ont., where he was administrator since its opening in 1953, to accept an administrative position at Merritt, B.C.

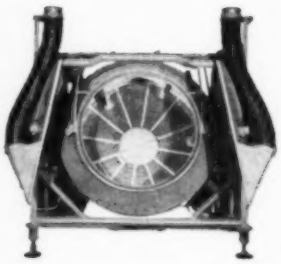
- N. R. Werezak, who has been secretary-manager at the Hafford Union Hospital at Hafford, Saskatchewan, for the past ten years, has resigned to accept a position in another town.

- J. R. McIlraith has tendered his resignation as secretary-treasurer of the Cobourg General Hospital, Cobourg, Ont.

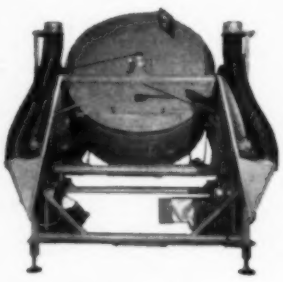
- Ivy Morrell is the new matron of the Grande Prairie Municipal Hospital, Grande Prairie, Alta.



This new 6-inch Fan gives Purkett Conditioning Tumblers about 20% more air... speeds up production



Purkett's 72" PCT* in loading position with vented doors swung clear. Handles 250 lb. load easily. Works automatically so that there is no interference with continuous operation.



It has now reversed itself to unloading position . . . notice break in blower duct. Automatic timer tells when it's time to unload and push button control does it automatically.

Provides more drying in the same length of time with shorter tumbling time possible.

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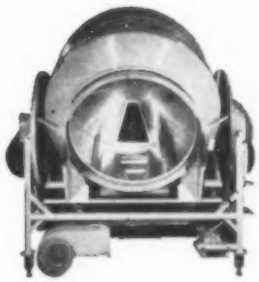
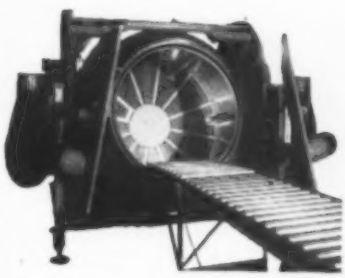


Unloading position from ironer side showing powerful 6" blower, also removable cleaning "door" to get to coils. Tumbling action speeds up ironing by eliminating costly manual shakeout; the goods are in a predetermined condition for better ironing.



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"Witch Doctors" are Really Doctors

It is beyond doubt that many of the undeniable successes of primitive medicine-men are due to unconscious but effective psychotherapy. But, in addition, the magico-religious ritual of the medicine-man contains on closer scrutiny numerous elements which will account for success beyond psychotherapeutic factors.

In the course of such rituals, whether they take place in the African bush, the South American forest, or among the Navajo of arid Arizona, magic potions are imbibed, which very often contain highly effective drugs, and magic manipulations and purification rites are performed, which correspond largely to our own physiotherapy.

The drug serpasil, for instance, so beneficial in high blood pressure and mental disease, is not a synthetic drug, like some of its predecessors (the arsenicals, or the sulfa-drugs) but is derived from a plant, *Rauwolfia serpentina*, which, for decades, medical missionaries in Africa had vainly pointed out to western pharmacologists as a very effective drug of primitives.

Serpasil is only one of many drugs of primitive origin which play an important rôle in our present-day pharmacopoeia. We mention here only such dramatically effective species as strophantine, the heart drug; emetine, used in amoebic dysentery; and picrotozine, the stimulator of respiration in barbiturate poisoning.

Cocaine and quinine once came from Peru. It would be useless to enumerate here all the effective emetics, purgatives, expectorants, and diuretics known to be used by primitives. It is quite obvious that besides useless substances—as they occur in all pharmacopoeias, even in our own—primitive pharmacopoeias contain a surprising percentage of effective drugs in spite of the magic ideas which govern their use.

Modern science has stood aloof from such studies among the "superstitious heathen" for at least a century. But lately, pharmaceutical industry has been sufficiently impressed by the potentialities of such studies to spend a considerable amount of money for research on primitive drugs.

Drugs are not the only effective therapeutic agents primitives use. During their rituals, physical agents of known value like baths of all sorts (including sweatbaths), massage, sucking (or dry cupping) are frequently and successfully applied. Except for sucking, which we have given up, we still practise them all.

Primitives are less active in the field of surgery than they are in drug treatment or physiotherapy. This is partly due to irrational attitudes, especially fear of mutilation, which is used by them rather for punishment or ritual than for treatment.—*WHO Bulletin.*

What Is It?

It is more powerful than the combined armies of the world.
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—*Hospital Safety Service.*

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Studies of Atomic Fallout

A recent press report from New York, U.S.A., stated that the Atomic Energy Commission is considering an expanded, long-range research program into the effects of nuclear radiation on man.

The program would place renewed emphasis on all phases of atomic radiation. This would include its creation and distribution from a nuclear bomb explosion or the reactor of an atomic power plant, its absorption by plant, animal and human life, and the effects it has on present and future generations.

The proposed expansion of research stems from the recent hearings conducted by a Joint Congressional Atomic Energy subcommittee into the dangers of radioactive fallout from atomic bomb explosions.

The biology and medicine division of the Commission has proposed a five-year program of accelerated and expanded research into the effects of radiation. This division is now spending about $20,000,000 annually for research on radiation. This, however, does not indicate the extent of the overall research effort, since studies are also being sponsored by other government agencies. Among them are the National Science Foundation and the Public Health Service.

The fields of expanded research under the proposed program would include the effects of radiation on future generations. Studies of the genetic effects of radiation thus far have been limited largely to animals.

Increased emphasis would be placed on genetic changes in humans. This might be the study of the offspring of survivors of the atomic bombings of Hiroshima and Nagasaki in Japan, particularly in families where cousins have married.

Distribution and uptake of radioactivity also would be studied under the new research program. This would include study of the natural and man-made radiation in the plants, animals and environment of various regions. The results would give a useful reference on how the amount of radioactivity is increased in an area by military or peaceful uses of the atom.

Be not angry that you cannot make others as you wish them to be, since you cannot make yourself as you wish to be.—*Thomas à Kempis* in *"Imitation of Christ"*

Medical Expressions

There is no end to the quiet but immensely exciting business of really getting acquainted with words. A word may appear dull and flat or worn and tired. But stop it and question it and you may find that behind the conventional exterior there is a fascinating, not to say romantic, history and "personality". Take some commonly used medical words for example (and not ponderous terms with doubtful classical pedigree either). *Delirium* in its literal sense means an improperly ploughed field. Roman farmers who took pride in their fields were especially concerned that the *lira* or furrows in ploughing were straight. A careless farmer whose furrows were wavy and irregular was said to be *delirare*. Thus a person whose mental faculties were disturbed and departed from normal was termed *delirius*. And so came our word delirium.

Another derivation from classical times and customs is the word *thyroid*. A light shield oblong in shape used by Greek soldiers was termed *thyreoeides* because it resembled a miniature door. When anatomists later came to describe the cartilage in the throat they adopted the name for the ancient shield—*thyroid*.

A very old term for the projection in the neck caused by the thyroid cartilage is *Adam's apple*. In typical deeply humorous fashion, the folk term saw in this protrusion, which moved up and down, a direct connection with the forbidden fruit, a piece of which stuck in Adam's throat. And so all his descendants — particularly males— inherited the lump caused by the bite of apple and Adam's reaction to it.

Older ideas of physiology and medical practice are reflected in modern phrases. *To learn by heart* suggests the ancient concept of the heart as the seat of the memory as well as the deeper emotions; while *to throw cold water* over some idea or suggestion recalls the custom of the 17th and 18th centuries. Then a demented patient was stripped and showered with cold water to reduce his excitability, based upon the idea that violently mentally disturbed individuals were suffering from "mental heat" due to an excessive concentration of humours. —*Dr. E. P. Scarlett* in *Historical Bulletin*.

It's but little good you'll do. watering last year's crops.—*George Eliot.*

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Doctor and Rescue Pilot

The only doctor in France who can fly a helicopter is a woman, Capt. Valérie André. She is also a trained parachutist and one of the most decorated women in the French Air Force.

Capt. André is now stationed at the air base of Brétigny, south of Paris, where she is the doctor responsible for flying personnel. An enthusiast about the medical rôle of helicopters, she has set up a heliport at the nearby Melun hospital. If there is an accident on the airfield, the injured can be carried rapidly to the hospital. Part of her job consists in training helicopter pilots. From time to time, she is suddenly sent to some remote part of the French Empire on special missions.

Born in Strasbourg, Mlle André won her private pilot's license when she was 16. However, the Second World War stopped her flying and she went to Paris to study medicine and wrote her thesis on the "psychotherapy of parachute jumping." She qualified as a parachutist in 1947. When she received her medical degree in 1948, she joined the medical corps with the rank of captain and was sent to Indo-China. She was assigned to a Saigon hospital but soon tired of routine practice in the wards and asked for more exciting duty. In 1949 she was attached to airborne troops to organize front-line first aid posts.

When she returned to the war in 1951, after a parachute rescue in the Laos hinterland and a period spent learning to fly a helicopter, she had a difficult time persuading her superiors of the logic of her demands for front-line duty, even though there were only two helicopter pilots in Indo-China at the time and neither of them a doctor. At first, she was allowed to go along with another helicopter pilot on his missions and finally in March 1952, she was allowed to go alone to pick up a couple of wounded Viet Namese soldiers.

For months she followed a busy schedule, shuttling back and forth between the front and a base hospital. When on duty, she made three or four trips a day—or night—most of the time in sweltering heat. She performed 165 rescues, bringing back some 300 badly wounded men in the baskets alongside her Hiller helicopter, landing in the jungle and sometimes with the enemy shooting at her at a range of 50 yards. She only crashed once on a routine flight far from the front. After two years her health broke under the strain and she was sent back to France in 1953.—*World Veteran.*

For Better Liaison

The School of Hygiene of the University of Toronto is looking into the general medical practices of Canadian doctors with the aim of creating better liaison between the general practitioner and the public.

The survey is the brain-child of the Canadian College of General Practice, and the university is working in collaboration with the independent C.C.G.P. organization.

The study is headed by two Toronto doctors, Dr. K. Clute and Dr. J. Firstbrook. They will journey across Canada, visit and interview practitioners, observing conditions under which they work and the type and volume of illness treated. The study is expected to last between two and three years.—*The Globe and Mail.*

Twenty Years Ago

(From *The Canadian Hospital*, October, 1937)

The following recommendations are made by the Committee on Medical Relations of the Canadian Hospital Council (with kind permission of the Ontario Medical Association). "We suggest that hospitals are sometimes too palatial, and equipment too elaborate. There should be provided in every large community one or more separate convalescent or rest-home wings or branches which could be carried on at a much lower cost than that of the hospital proper.

"The patient should be constrained to enter the class of ward which he can afford.

"The medical staff should exercise discretion in prescribing only those medical investigations which are really indicated.

"Small hospitals should not attempt diagnostic and therapeutic procedures for which skilled personnel is not available.

"In the management, the greatest economy should be exercised, with special attention paid to linens, food stuffs, medical supplies and the incinerator.

"Payment to student nurses should be reduced at least, on the ground that in no other profession are apprentices given room and board. This course would entail the abolition of any other labour by student nurses than that required in the course of learning their profession.

"The use of graduate nurses in smaller hospitals in place of student nurses, flat rates for hospital services, deferred payment plan, group nursing, collective buying, and part-time specialist services, are other means of reducing costs where circumstances warrant, and should be investigated."

What Criticisms of Our Hospital System are Most Frequently Encountered?

All criticisms which are based upon misapprehension should be corrected as far as possible. This is a stupendous task because the public loves to misunderstand its benefactors, but the various avenues of publicity, particularly the spoken word of hospital workers should be utilized as far as possible . . . Criticisms which are well founded should be taken seriously . . .

(a) Financial burden at time of sickness too high on average individual.

(b) Present hospital system de-

signed for the poor and for the wealthy.

(c) Hospital provision incomplete. Many diseases not adequately provided for.

(d) Diagnostic services too expensive.

(e) Hospitals lack a strong financial foundation. Endowments unknown in most hospitals. Municipal and provincial grants, although generous, insufficient to prevent deficits.

(f) Lack of sufficient supervision in some hospitals of the work done therein by medical practitioners.

(g) Conversely, the criticism is also expressed that many medical men are restricted in their use of hospital facilities.

(h) Overlapping of districts, two or more hospitals serving the same district.

(i) Lack of "personal touch" and sympathy on the part of many of the hospital personnel.

(j) Business efficiency. Criticisms here are contradictory. Hospitals are said to be too businesslike and mercenary in demanding payment by patients and on the other hand, municipal authorities state that their deficits are often due to lack of good business principles in collecting accounts, in demanding efficiency, et cetera.

(k) Doctors complain bitterly that they are badly imposed upon by being requested constantly to attend patients in public wards and out-patient departments without remuneration, as well as caring for their free patients in private practice. Moreover, they are the first ones called upon to subscribe to any hospital construction. Doctors give a great deal of time to the training school without remuneration.

(l) Many patients feel that their hospital care should include full nursing service and that they should not be compelled to employ "specials".

(m) Paying patients object to having to pay not only for themselves but for part of the maintenance of the indigent patients. This is due to faulty legislation.

(n) In the hospital itself patients are antagonized against hospital very often by such details as noise, "hospital smells", press reference to hospital accidents, gossip by pupil nurses and their seniors and other factors.

The virtue of all achievement is victory over oneself. Those who know this victory can never know defeat. — *A. J. Cronin*

Hostel for Patients' Relatives

Hospitals in rural areas are constantly faced with the problem of accommodating the relatives of patients who are seriously ill, or relatives of patients who have been brought in during the evening and for whom no public transport is available for the journey home. Occasionally patients are admitted who live in other parts of the country but have been involved in sudden illness or accident and this sometimes brings with it the question of visiting, and accommodation for the visitors.

These needs, as well as others of a similar nature, have recently been met in Winchester, England, through the generosity of the Trustees of the former Winchester and District Contributory Scheme Fund.

The hostel, designed by a local architect, is in the form of a modern bungalow and provides accommodation for four people to stay over night and for a larger number during the day in the spacious lounge. No meals are provided in the hostel. The relatives are able to obtain them either in the dining-rooms or in the staff canteen where, of course, they pay the normal charges.

Occupants of the hostel are expected to look after their rooms, to make their own beds and generally to care for the place, although the cleaning services are provided by the hospital. Care is taken to ensure that the privileges are not abused—for it is not intended to provide lodging free of charge where people are able to pay hotel charges but in all deserving cases the services of the hostel are freely available. Thus in cases where a ward sister knows of a relative who genuinely needs accommodation the hostel is immediately brought into use.

A second use to which the building is put is to accommodate nursing mothers whose infants are patients of the hospital. Accommodation of these mothers has often in the past presented difficulty even where by arrangement billets were available in the town. Through the use of the hostel these difficulties no longer exist.

Before construction, records were available to show the potential demand for such accommodation and the forecast has been entirely justified by the experience gained since it was opened.

The hostel is situated on the hillside below the hospital and has extensive views to the south-east. The walls are of 11-inch cavity construction, externally faced with bricks. The roof is of three-layer bituminous felt on 2-inch Thermacoust slabs. The windows are metal casements in the bedrooms, bathroom and pantry, and the living room has a purpose-made wooden window, double glazed. The floors are covered with linoleum tiles in the hall, bathroom, cloakroom and pantry. There are hard wood blocks in the bedrooms and oakstrip in the sitting room. Hot water for the bathroom and bedroom wash basins comes from a multi-point electric storage heater. A small electric water heater heats the sink in the pantry. Heating is by electric tubular heaters, and an open fire in the sitting room.—*The Hospital.*

This above all: to thine own self be true.—*Shakespeare.*

You Were Asking

(concluded from page 62)

bers, are among the many things of value in the course.

Perhaps the most singular benefit is that the knowledge of my profession, which had been acquired over a number of years on largely "a learn by doing" method, has now been given a formal basis. This means that knowledge acquired in the future will of necessity also be placed upon this same solid foundation. One cannot put too much emphasis on this aspect of the course.

As a result of the foregoing I find I am approaching my job with greater confidence due to no small extent upon a greater appreciation and knowledge of the whole field of hospital administration. Greater confidence and knowledge lead to greater efficiency.—*W. C. Duncan, Lieutenant (M.A.d)*

St. Joseph's Hospital,
North Bay, Ontario.

NOT until the course in Hospital Organization and Management was completed did I fully realize the tremendous value derived from:

(1) Integrating various hospital departments and the importance of smooth interlocking of these departments to efficient and intelligent functioning. The necessity of understanding, tolerance, consideration and awareness of the human element in personnel relationships.

(2) Broadening of viewpoint, incidental to meeting with hospital personnel from various parts of the country. The discussion of problems, with comparison and valuation of viewpoints.

(3) Research—knowledge for itself—with a better understanding of my own particular sphere, thus giving me fresh impetus to improve methods and to look for new procedures, with a determination to avoid ruts.

(4) It has given me a new respect for the tremendous work that hospitals are doing for society not only in the realm of treating illness, but with regard to social security and education in healthful living, through preventive medicine.

(5) Personal education has been broadened through meeting delightful people and a faculty that was keenly interested and anxious to impart knowledge for the betterment of our hospitals and for the patients we serve.—*Sister M. Paula, Office Manager and Accountant.*

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Home Care Plan

(continued from page 72)

months was noted. The hospital discharged to the plan 116 patients. Hospital days saved amounted to 1,559 or an average of 13 days per patient, or the equivalent of 4.3 hospital beds in continuous use for the year. There were 597 nursing visits made or one visit per 2.5 days of service. Patients on housekeeping services required an average of 46 hours of service. Thus, as the service became better established, there has been an increase both in the number of patients referred and in the amount of service rendered to each patient. The types of patients include: 74 per cent medical, 22 per cent surgical and 4 per cent obstetrical cases.

For the year ended March 31st, 1956, the figures have increased considerably: 199 patients were on the service as against 116 for 1953; hospital days saved were 2,137 against 1,559; a saving of 5.9 hospital beds in continuous use for the year as against 4.3 for 1953; so it can easily be seen that the Hospital Home Care Plan was gaining in popularity with the patient and the medical staff of the hospital. The percentage of cases had changed somewhat for 1956 as against 1953. Medical was now 67 per cent as against 74 per cent; surgical 16 per cent as against 22 per cent and maternity had taken a substantial increase, 17 per cent instead of 4 per cent. We think the reason for this increase in maternity was that at the outset, doctors seemed reluctant to let patients out of hospital for less than 10 days after confinement, but by 1954 they had realized that the plan was a good one and they were willing to discharge patients at an early date provided they were transferred to the Hospital Home Care Plan.

Cost of Administering the Plan

In 1953, the over-all per diem cost of the plan for the year was $2.06 as against the hospital's per diem cost of $11.35 for an all-inclusive hospital service. Revenue from patients under the plan has not been taken into consideration in calculating the per diem cost.

In 1956, the per diem cost of the plan for the year increased, as did everything else, to $2.15 as against the hospital's per diem cost of $12.40. Again revenue from patients has not been taken into consideration. Revenue for that period was $408.75. It must be clearly understood that the low cost is due in large part to the establishment of

the service within the framework of the existing health agency. Thus, although the service load has increased, certain administrative costs have not increased appreciably. Further, as part of the generalized public health program, the Hospital Home Care Plan can be carried out with economy of nursing time since duplication of visits and travel is eliminated. This is demonstrated by the fact that for the period January 1st to Sept. 30th, 1953, the plan took about 8 per cent of the time of the administrator, three and one-half per cent of the time of one clerk and four and one-half per cent of the time of each of the three public health nurses or approximately seven hours per month per nurse.

Now, this is all very well for the Vernon area and the Vernon Jubilee Hospital. We have no worries financing the plan as it is financed by government grants. You may ask, and rightly so, "What would the plan have cost our community if there had been no grants?" This is the answer. Provided that the plan was administered by the Department of Health and Welfare, with figures we now have on hand after years of experience, and taking into consideration revenue from patients based on past experience, it would have cost the Vernon area served by the plan, 14 cents per capita per annum, 14 cents for every man, woman and child in the area. In the Vernon area which includes 20,000 people it would amount to $2,800 which is exactly what the plan cost for last year *after* deducting revenue from patients under the plan.

If any area is considering instituting a plan such as the one in the Vernon area the first steps to be taken are (1) enlist the co-operation of your local health agency; (2) sell your local municipal authorities on the idea of a Hospital Home Care Plan which will cost them (based on present day costs) 14 cents per capita per annum in the area you intend to cover by the plan. If you do institute such a plan I can assure you, as administrator of a hospital who has such a plan in operation, you will be very pleased with the results.

A woman with a newly-developed interest in government wrote to the editor of a newspaper: "I want to get into politics. Do the taxpayers have a party?" The editor answered her letter, writing: "Very seldom, lady, very seldom."—*English Digest*

Classified Advertising

Associate Director of Nursing

Applications are invited for the position of Associate Director of Nursing at the Sudbury Memorial Hospital, Sudbury, Ontario. This hospital of approximately 300 beds has been in operation since February 1956. For further information apply—Director of Nursing, Memorial Hospital, Sudbury, Ontario.

Dietitian Required

Sudbury Memorial Hospital, by March 1, 1958. Assistant to take charge of Therapeutic Diets and assist with administration in a recently opened hospital with modern dietary department; central tray service. Liberal salary and vacation; excellent personnel policies. Apply to: Chief Dietitian, Memorial Hospital, Sudbury, Ontario.

Accountant Wanted

For 182-bed hospital, new position; background in machine accounting would be an asset. Apply assistant administrator, Notre Dame Hospital, North Battleford, Saskatchewan.

X-Ray Technician

Female, registered preferred, 100 bed accredited hospital. For further details apply to administrator, Norfolk General Hospital, Simcoe, Ontario.

Science Instructor
for
Brandon General Hospital
School of Nursing
Brandon, Manitoba.
60 Students
Two classes per year.
148-Bed Hospital
Duties to commence immediately. For further information please apply to Director of Nursing.

Administrator Available

1957 graduate "C.H.A." Hospital Organization and Management Course". Eighteen years hospital experience, excellent references. Would welcome opportunity of interviews for the position of administrator. Please write to Box 903T, The Canadian Hospital, 57 Bloor Street West, Toronto 5.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

MARY A. JOHNSON ASSOCIATES
11 West 42 Street, New York 36, N.Y.
Mary A. Johnson, Ph.D., Director

Position Wanted

Hospital Administrator or Assistant

Management specialist, age 37, with experience in sales, personnel, office procedures, purchasing, maintenance and repairs, etc. B. A. Degree, Monmouth College. Fifteen years experience and interest in health field and administration, fund raising, and community problems. Married, two children. Finest references and credentials. Will relocate anywhere.

Reply: Mr. Maurice A. Garland, 723 East Euclid Avenue, Monmouth, Illinois, Telephone 887.

MEDICAL RECORD LIBRARIAN WANTED

Experienced Medical Record Librarian is required for large teaching hospital in Eastern Ontario. Good salary and personnel policies and appointment can be arranged to suit the convenience of the applicant. Apply Superintendent, Ottawa Civic Hospital.

New Teaching Hospital

The Lord Mayor of Sheffield, Alderman A. Ballard, chairman of the board of governors of the United Sheffield Hospitals, has recently cut the first sod on the site of the new teaching hospital in Sheffield, England. Ultimately it will have accommodation for 800 beds and will cost between £3,000,000 and £4,000,000, with an annual maintenance cost of about £750,000, employing some 1,600 people. The out-patients department will be the first to be built and will take two years to complete. Buildings for 252 in-patients will follow.

In 1939, a national architectural competition was held for the design of the building; Adams, Holden and Pearson, FF.R.I.B.A., architects of the new Westminster Hospital, were the winners.

PHYSICAL THERAPIST WANTED

Position for a physical therapist is open at a fully accredited chronic disease hospital located near large east coast city in the United States. Applicants should be versed in the concepts of rehabilitation, competent to serve as a member of a therapy team, and able to minister successfully to older people.

Application may be made by: interview with Dr. Mary Johnson, Royal York Hotel, Toronto, Ont., October 27 - 31st; or by letter including resumé of training, experience, and salary expected, addressed to Box 1103A, The Canadian Hospital, 57 Bloor St. West, Toronto 5, Ont.

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Community-Auxiliary Relations

(concluded from page 68)

In the final area—volunteer service—the relationship is less easy to define, perhaps because the work here is in a stage of transition and new opportunities for service are constantly being presented. But because the work done is directly for the hospital and the patient, completion of a task assigned brings with it a satisfying sense of achievement. An enthusiastic interest in such volunteer work is being shown by auxiliary members everywhere.

The development in this area emphasizes the growing partnership between the hospital and the auxiliary and the increasing importance of well established lines of communication. With the adoption of a volunteer program, the education of the auxiliary member broadens and her understanding of the hospital and its policy deepens. The hospital, on the other hand, finds the volunteer worthy of the time and effort spent in integrating her service into the general framework.

Conclusion

The auxiliary contributes to its hospital:

(a) as a source of financial assistance (or its equivalent in donations); (b) as an educational force in the community; (c) as a source of good public relations; and (d) as a stimulus to greater achievements and higher standards in the hospital. The closer the relationship between these partners, the more satisfying will be the achievement. Hospital policy and auxiliary policy will be mutually understood and integrated for the greatest good of the patient.

In closing I quote a sentence from our prize-winning essay of last year: "Our time, the products of our talents and hard work are unstintingly given because we, the women of the community, realize the importance of a hospital in the vicinity. We will support it".

Do these last four words I wonder, give us our most important clue to hospital-auxiliary relations?

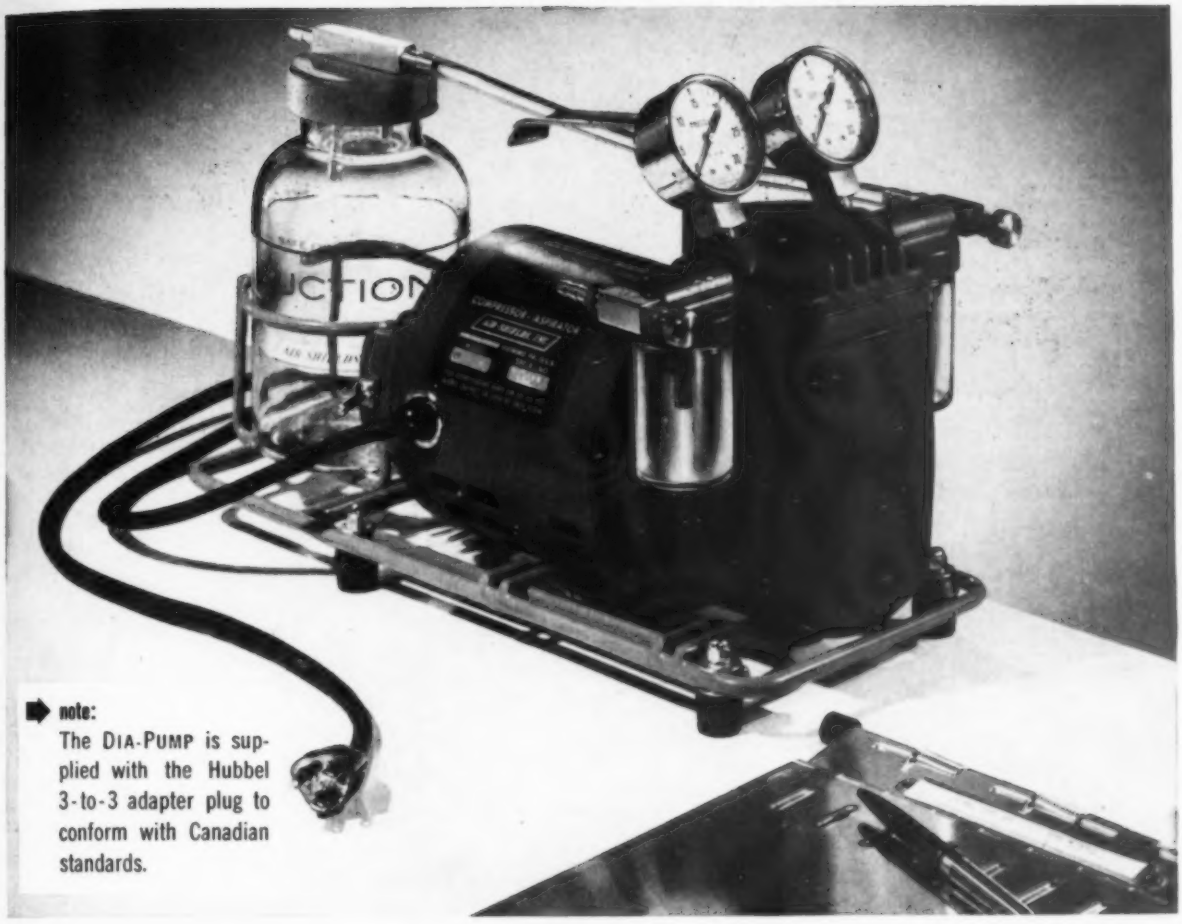
Cleaning Marble

When marble becomes especially dirty or stained, try the "poultice method". This method draws out stains and secures a more uniform result than is possible with surface scrubbing. It is applicable to carved surfaces and works on sand finished, honed, or polished marble, both interior and exterior.

Mix a mildly alkaline abrasive cleaner with hot water to form a thick smooth paste the consistency of wet cement and stiff enough to adhere to the face of the marble. Wet the marble surface and apply poultice paste with a trowel or spreader to form a thickness of about ½ in. The poultice should shut off air from the entire face of the area being cleaned for about 48 hours, or until thoroughly dry.

To remove the poultice, dampen it to avoid dust and use a wooden paddle to avoid scratches. The stone should be rinsed thoroughly with clean water and wiped dry. —*Institutions Magazine.*

To endure is greater than to dare; to tire out hostile fortune; to be daunted by no difficulty; to keep heart when all have lost it; to go through intrigue spotless; to forego even ambition when the end is gained—who can say this is not greatness?—*William Makepeace Thackeray.*



note:
The DIA-PUMP is supplied with the Hubbel 3-to-3 adapter plug to conform with Canadian standards.

New portable compressor-aspirator unconditionally guaranteed for 1 year!

The new AIR-SHIELDS DIA-PUMP* is designed for continuous operation wherever regulated suction or oil-free compressed air is needed. Portable, rugged, quiet, and virtually trouble-free, the DIA-PUMP has been test-run continuously, day and night, for an entire year without failure of any part, and is unconditionally guaranteed for 1 year. This compact, new diaphragm-type compressor-aspirator cannot rust, "freeze" or jam from condensed or aspirated moisture, provides filtered, *oil-free* air at controlled pressures up to 30 pounds, or controlled suction up to 23 inches of mercury. *Standard model:* 1/6 HP motor, 115 volt, 60 cycle A.C., with ground wire and adapter plug for 2 and 3-pronged outlets. Special models available for use with other currents. Write us for DIA-PUMP folder, or phone collect from any point in the Dominion. AIR-SHIELDS (Canada), Ltd., 8 Ripley Ave., Toronto 3, Ont. (Roger 6-5444).

Dia-Pump*

Sold in Canada by **AIR-SHIELDS CANADA, LTD.**

*Trademark

News Released by Hospital Supply Houses

By C.A.E.

J. A. Montgomery with Lily Cups

Mr. H. R. Kobrick, President of Lily Cups Limited, has announced the appointment of Joseph A. Montgomery as sales promotion manager. Well known in advertising circles, and an active member in the Advertising and Sales Club of Toronto, Mr. Montgomery comes to Lily Cups with extensive experience in sales promotion and advertising in an allied paper field.

J. A. Montgomery

Fisher & Burpe Announce Conductive Cleaner

Protection for costly investments in conductive flooring is now offered with Kare Conductive Cleaner. Kare keeps already conductive floors within safe limits of ohm resistance as set out by the National Research Council and N.F.P.A. codes. It guards against explosions due to its complete rinsibility, its non-alkaline reaction on the surface and its ability to clean without harsh scrubbing.

Kare was formulated with the assistance of one of Canada's leading hospitals and is a custom-made all-Canadian product manufactured under strict laboratory control.

While Kare is normally available in 275 pound drums, a 40 pound trial size pail is currently being offered. Testing devices, conductive rubber accessories and other safety equipment is available to enable hospitals to establish a definite safety program. For complete details contact Fisher & Burpe's head office at 219 Kennedy Street, Winnipeg 1, Manitoba.

Robert Viau with Johnson & Johnson

Johnson & Johnson Limited announces the appointment of Mr. Robert Viau as hospital sales representative covering the eastern part of the Province of Quebec. Mr. Viau will make his headquarters in Quebec City.

Robert Viau

Cry-O-Therm Gas Sterilization

A significantly new and advanced device for gas (ethylene oxide) sterilization developed by the American Sterilizer Company, Erie, Pa. is the Cry-O-Therm.

Climaxing more than eight years of intensive research and development, the new Cry-O-Therm is designed for rapid and effective sterilization of heat or moisture and laboratory supplies. It is said that it differs from other gas sterilizing equipment in that it uses special 11% ethylene oxide known as Cry-Oxcide. The new gas is packaged in low pressure, disposable aerosol containers. One or two cans are used for each load depending upon whether a two or four hour cycle is required.

Of especial interest to hospitals is the fact that the extreme permeability of Cry-Oxcide permits protective wrapping or pre-packaging of instruments and supplies to be sterilized. Items for immediate hospital use may be wrapped in muslin or paper in much the same fashion as for steam or dry heat sterilization. Items for prolonged periods of storage may be packaged in polyethylene film, protecting their sterility almost indefinitely.

Chamber capacity of the unit is 16″ by 16″ by 30″.

Complete details are available from the American Sterilizer Company, of Canada Limited, Brampton, Ontario. Request Bulletin SC-310.

Batteryless Rechargeable Flashlight

For the first time an everlasting flashlight is available with many outstanding features and hundreds

(concluded on page 132)

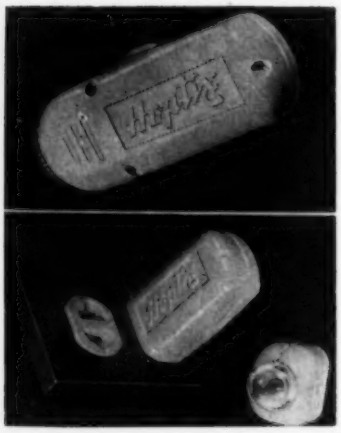
Across the Desk

(concluded from page 130)

of uses. Rugged, safe and durable, the Hoptix flashlight requires no batteries.

Introduced by Major Electric Co. Ltd., 400 McGill St., Montreal, the German made Hoptix pocket flashlight is recharged by the removal of the snap-off cap, and plugging into any 110-120 volts, 60 cycle, A.C. outlet. Full recharge of about 12 hours is claimed to cost less than a cent, though this amount of recharge time is rarely needed. It is quite impossible to come into contact with any of the conducting parts of the Hoptix during recharging. A built-in fuse prevents the flashlight from being overcharged, and the bulb cannot be burnt out during recharging, since it is integral with the removable cap. When recharged, the snap-off top is replaced, and the light is ready for use.

The unit is contained in an ivory



plastic case 4 x 1½ x 1" and weighs 3½ ozs., making it convenient for pocket or purse.

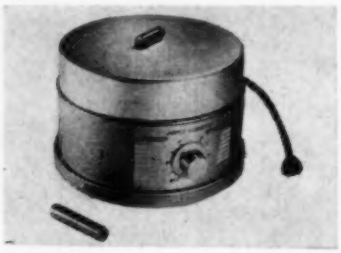
When fully charged, even after long storage, the Hoptix flashlight will remain bright for two hours, and its operation is not subject to climatic conditions. Replacement bulbs are available, and the flashlight is guaranteed for 1 year on the condition that the sealed screws are not tampered with.

Newest Fisher Stirrer

Magnetic Stirring, an important means for complete mixing of laboratory solutions, is the basis of the newest stirrer developed by Fisher Scientific (which recently pioneered "stirring hotplates", "oscillating hotplates", and a variety of other appliances in the field).

The new Fisher Jumbo Magnetic Stirrer handles liquids of a wide viscosity range in quantities up to 3 gallons.

Any glass, porcelain, nonmagnetic metal or plastic vessel can be used, open or closed, even sealed under vacuum or pressure. Contents are mixed quietly, at speeds



starting at an almost stationary "low" to "high".

Magnetic lines of force do the work, eliminating contaminant-collecting shaft and impellers of mechanical stirrers, permitting full access to the top of the container. A Teflon-sealed Alnico magnetic bar, placed inside the container, revolves at the same speed as the stirrer motor (which is rated at 1550 rpm).

The new low silhouette (9" top diameter, 9-1/16" bottom diameter, 6⅜" high) and 3 sturdy rubber feet make the unit wobble-proof.

For further information please write to: Fisher Scientific Ltd., 8505 Devonshire Road, Montreal 9, Quebec.

Georges Monette

W. F. MacEachern

E. A. Steadman

Smith & Nephew Appointments

Mr. G. W. Walker, Sales Director of Smith & Nephew Limited, Montreal, announces the following three appointments: Mr. Georges Monette, who will augment the sales force in the Province of Quebec. Mr. W. F. MacEachern will represent the company in the Maritimes and Newfoundland. Mr. E. A. Steadman has been appointed to represent the company in the Province of Saskatchewan.

A.T.I. Nipple and Catheter Bag

A new SteriLine Nipple Bag for terminal sterilization of infant formula and a 24" SteriLine Bag for pipettes and extra long catheters have just been added to Aseptic Thermo Indicator Company's line of indicator bags.

The Nipple Bags contain a special formulation of the well known "built-in" indicator employing a purple sensitive ink which changes to green after the infant formula, mouth of the bottle and nipple have been subjected to the proper sterilizing conditions of time, steam and temperature.

These nipple bags leave no doubt whatsoever that terminal sterilization conditions of 10 minutes at 230°F. or its time and temperature equivalent, are maintained.

For a generous supply of samples and information, write Aseptic-Thermo Indicator Company, 11471 Vanowen Street, North Hollywood, California.

Institutional Products Catalog Announced by Colson

The publication of a new catalog of hospital and institutional equipment has been announced by the Colson (Canada) Limited, Toronto 12.

Included in the revised listings are Colson's complete line of wheel chairs, and wheel chair accessories, orthopedic carts, dish trays, tray trucks, inhalators, linen hampers, wheeled stretchers, and surgical carts and tables.